86-747

No.

In The

Supreme Court Of The United States

OCTOBER TERM, 1986

STEPHEN B. HEINTZ, Commissioner of the Connecticut Department of Income Maintenance,
Petitioner,

v.

DALE HILLBURN, by his parents and next friends Ralph and Eleanor Hillburn, et al.,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOSEPH I. LIEBERMAN
Attorney General

HUGH BARBER
Assistant Attorney General
Counsel of Record

90 Brainard Road
Hartford, CT 06114
(203) 566-7098
Counsel for Petitioner

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66 Connecticut Boulevard
East Hartford, CT 06108
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QUESTIONS PRESENTED

1. Does the Medicaid Act authorize a requirement that Title XIX provider agreements with skilled nursing facilities be terminated based upon findings of inadequate care provided to individual Title XIX-assisted patients, when the facilities as a whole have been determined to be qualified to participate in the Medicaid program by the state health inspection agency or the U.S. Department of Health and Human Services?

2. Does the provision in the Medicaid Act requiring the single state agency to inspect the adequacy of care provided to Title XIX-assisted patients, 42 U.S.C. § 1396a(a)(31), require the single state agency to review the plan of care developed for each such patient by their personal physician in order to affirmatively determine that the care provided to each patient is adequate?

3. Is the requirement of 42 U.S.C. § 1396a(a)(31) pertaining to the obligation of the administering state agency to inspect the adequacy of care provided to individual Title XIX-assisted patients enforceable by a private § 1983 cause of action?

PARTIES TO THE PROCEEDING

The following are named as parties to the proceeding in the Court of Appeals for the Second Circuit:

Dale Hillburn, by his parents and next friends Ralph and Eleanor Hillburn;

James Corbett, by his next friend Roberta Reid;

Sandra Fuchs, by her mother and next friend Florence Fuchs;

Stephen Kaplanka and Mark Kaplanka, by their mother and next friend Dorothy Napolitano;

Edward Maher, Commissioner of the Connecticut Department of Income Maintenance; and

New Brook Hollow Health Care Center, Inc.

Stephen B. Heintz' name has been substituted for that of Edward Maher as Commissioner of the Connecticut Department of Income Maintenance pursuant to Rule 43(c) of the Federal Rules of Appellate Procedure and Rule 40.3 of the Rules of this Court.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

The petitioner, Stephen B. Heintz, Commissioner of the Connecticut Department of Income Maintenance, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Second Circuit which entered in this case on June 30, 1986.

OPINIONS OF THE COURTS BELOW

The opinion of the Court of Appeals is reproduced in the Appendix at 3A, and is reported at 795 F.2d 252.

The opinion of the District Court for the District of Connecticut has not been reported. The opinion and judgment of the District Court is reproduced in the Appendix at 36A and at 77A, respectively.

JURISDICTION

The judgment of the Court of Appeals for the Second Circuit was entered on June 30, 1986. A timely petition for rehearing was denied by the Court of Appeals on August 6, 1986. This petition is filed within ninety days from the denial of the petition for rehearing. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The orders below are based upon 42 U.S.C. § 1396a(a)(31), as implemented by 42 C.F.R. § 456.600–§ 456.614. The verbatim text of the statute and of the implementing regulations is set forth in the Appendix.

In order to determine whether the orders below are properly based upon 42 U.S.C. § 1396a(a)(31) and its implementing regulations, it is necessary to consider the below listed related statutory and regulatory provisions, which are also set forth verbatim in the Appendix.

42 U.S.C. § 1396a(a)(5)
42 U.S.C. § 1396a(a)(9)
42 U.S.C. § 1396a(a)(23)
42 U.S.C. § 1396a(a)(28)
42 U.S.C. § 1396a(a)(33)
42 U.S.C. § 1396i
42 C.F.R. § 431.10(e)
42 C.F.R. § 431.151
42 C.F.R. § 440.40(a)
42 C.F.R. § 442.12
42 C.F.R. § 442.105(a) & (b)
42 C.F.R. § 489.12

STATEMENT OF THE CASE

The petitioner, Stephen B. Heintz, the Commissioner of the Connecticut Department of Income Maintenance, (hereinafter the "Department"), is the head of the single state agency charged with administration of Connecticut's Medicaid program. This class action lawsuit was brought by severely disabled Title XIX-assisted patients of Connecticut skilled nursing facilities who claimed in their Complaint that they required adaptive wheelchairs for medical reasons but that skilled nursing facilities had failed to provide such equipment. The District Court had jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 28 U.S.C. § 1343. A plaintiff class was certified by the District Court as including "(m)edicaid recipients residing in or admitted to Skilled Nursing Facilities in the State of Connecticut on or after February 18, 1982, who, under defendant's policies and practices, cannot obtain the adaptive wheelchairs necessary to maintain their health and insure their effective development." Ruling on Plaintiffs' Motion to Amend Class Certification (filed Sept. 18, 1984) at p. 3.

Even though this action involves the quality of care provided by nursing facilities, the state health inspection agency is not a party to this proceeding. Furthermore, the skilled nursing facilities of Connecticut are not parties to this proceeding, notwithstanding that the quality of care provided by such facilities is at issue and that the petitioner was ordered to take "corrective action" against such facilities including termination of provider agreements.

At the conclusion of a five day trial, the District Court found that adaptive wheelchairs are pieces of equipment that are designed to support and properly position a disabled person's body whose disabilities preclude the effective use of a standard wheelchair. App. 47A. The Court further found that for some individuals adaptive wheelchairs are medically necessary in that they are helpful in preventing contractures and in facilitating safe and proper breathing, swallowing and

digestion. App. 48A. The Court, however, acknowledged that adaptive wheelchairs have only become available for disabled adults in recent years, that they still are not widely available for disabled adults, and that skilled nursing facilities may have difficulty in obtaining appropriate adaptive wheelchairs for their residents. App. 48A.

The Court ruled, citing *Blum v. Yaretsky*, 457 U.S. 991, 1011 (1982), that the Medicaid Act does not require the single state agency to become a medical provider of adaptive wheelchairs or related services. However, the Court found that skilled nursing facilities are required to provide such equipment and related services in order to comply with the conditions of participation applicable to such facilities. App. 63A. The Court further found that the Department had failed to fulfill its responsibility as the single state agency to inspect the adequacy of care provided by such facilities and to take "corrective action as needed" based upon the findings of its medical review teams. 42 U.S.C. § 1396a(a)(31). The Department acknowledged in the course of the proceeding that its patient review teams did not "second guess" the adequacy of the patient's plan of care as developed by his physician—but instead, focused on whether the physician developed plan of care was being implemented by the facility. The District Court held that by not evaluating the adequacy of the physician developed plan of care, the Department could not fulfill its obligation to conduct inspections of the adequacy of care provided by such facilities. App. 65A. Furthermore, the District Court ruled that the Department had failed in its responsibility to take "corrective action" by not finding facilities deficient when adaptive wheelchairs were not provided and by not terminating the provider agreements of deficient facilities.

An elaborate judgment consistent with the Court's memorandum of decision was entered on October 8, 1985. App. 77A. The judgment enjoins the Commissioner, through the Department's medical review teams, to identify potential class members who are, in turn, to receive an interdisciplinary

assessment by a team to be convened by the nursing facility. The Commissioner is enjoined to determine whether skilled nursing facilities are meeting the adaptive wheelchair and related service needs of such patients and to take "corrective action" against any skilled nursing facility that fails to comply. Corrective action is defined in the judgment as including the filing of complaints with the state health inspection agency for whatever action that agency deems appropriate under state law; however, whenever other steps fail to correct a facility's deficiencies, the Commissioner is enjoined to terminate the skilled nursing facility's provider agreement. It is this aspect of the judgment which is of particular concern since it mandates the termination of provider agreements notwithstanding that the facility is certified as being qualified to participate in the program by the state health inspection agency or the United States Department of Health and Human Services. App. 84A.

The Court of Appeals upheld the judgment of the District Court, ruling that the District Court correctly concluded that the Department had failed to properly conduct inspections of the adequacy of care provided by such facilities. App. 18A. Furthermore, the Court of Appeals construed the judgment of the District Court as only requiring the termination of provider agreements of "irremediably noncompliant" facilities and held that the judgment, so construed, was "not precluded" by the Act. In support of its conclusion that the judgment of the District Court was not precluded by the Medicaid scheme, the Court of Appeals cited the single state agency principle, 42 U.S.C. § 1396a(a)(5), 42 C.F.R. § 431.1 and 431.10, requirements that the state agency provide appeal procedures when terminating "certification *or* a provider agreement for the Medicaid program" (emphasis in original), 42 C.F.R. § 431.151, and the "denial for good cause" exception of 42 C.F.R. 442.12(d). App. 21A–24A. Even though the issue of the availability of a § 1983 cause of action was properly raised, the Court of Appeals did not discuss this issue except insofar as it may have denied this claim by ruling that, "[w]e have considered all of the arguments advanced by CDIM in support of its cross-appeal and have found them to be without merit." App. 24A.

A timely petition for rehearing was filed by the Department, which petition for rehearing was denied by the Court of Appeals on August 6, 1986. App. 34A.

REASONS FOR GRANTING THE WRIT

I. THE RULING OF THE COURT OF APPEALS RAISES ISSUES OF FUNDAMENTAL IMPORTANCE CONCERNING THE SCOPE OF RESPONSIBILITIES OF THE SINGLE STATE AGENCY FOR PURPOSES OF ADMINISTRATION OF THE MEDICAID PROGRAM AND THE AUTHORITY OF A COURT TO ENTER REMEDIAL RELIEF, WHICH RULING CONFLICTS IN PRINCIPLE WITH THE PRIOR RULINGS OF THIS COURT AND OF THE COURTS OF APPEALS.

The holding of the Court below raises fundamental issues of extreme importance concerning the scope of responsibility of the administrative single state agency to inspect the adequacy of care provided by participating skilled nursing facilities and to take "corrective action," including termination of provider agreements, based upon its findings.

There are currently some twenty-three thousand patients residing in three hundred and four nursing homes in Connecticut. Approximately two-thirds of these patients receive Title XIX assistance for the cost of nursing facility care. Nearly all of these Title XIX assisted patients are infirm and elderly, requiring substantial assistance in activities of daily living in addition to the medical care provided by nursing facilities. Furthermore, very few of these patients are classmembers in this action. As a result of the mandatory provisions of federal law, these individuals are entitled to receive assistance for the cost of nursing facility care provided by the qualified provider of their choice. 42 U.S.C. § 1396a(a)(23).

Scattered throughout Connecticut's nursing facilities are some several hundred severely disabled, Title XIX-assisted individuals who are classmembers in this action because they

may benefit from the provision of adaptive wheelchairs and related services. As a result of the ruling of the Court below, if a nursing facility fails to adequately provide an adaptive wheelchair or related services to a single classmember who resides in a nursing facility, the petitioning single state agency may be enjoined to terminate the provider agreement of the facility, thereby denying assistance to all of the patients in the facility, nearly all of whom are *not* classmembers in this action. In the event of termination, the facility will have little choice but to transfer all of its Title XIX-assisted patients to other facilities—which can have a deleterious effect on the health and welfare of these elderly and infirm patients.

Furthermore, the holding of the Court of Appeals has important ramifications that extend far beyond the provision of adaptive wheelchairs in Connecticut nursing facilities. The holding of the Court of Appeals would support the entry of similar orders throughout the circuit whenever any individual, or groups of individuals with similar characteristics, can convince a court that their needs are not adequately being met. Given the need for national uniformity, and the likelihood of similar litigation, there is a compelling need for this Court to clarify the responsibilities of the administrative single state agency for purposes of quality of care enforcement.

The requirement that the petitioner terminate provider agreements based upon individual deficiencies is not only harsh, it squarely conflicts with the right of all of the Title XIX-assisted patients in the facility to receive assistance from the qualified provider of their choice. 42 U.S.C. § 1396a(a)(23). By clear and express provisions in the Act, whether a facility is qualified to participate in the program is dependent upon the certification decision of the state health inspection agency or the United States Department of Health and Human Services. Skilled nursing facility services are defined as services "provided by a facility . . . *that is certified* to meet the requirements for participation under Subpart C of Part 442 of this Subchapter, as evidenced by a valid agreement between

the Medicaid agency and the facility."[1] 42 C.F.R. § 440.40 (emphasis added). Whether the state health inspection agency or the Secretary is responsible for the certification function depends upon whether the facility also participates in the Medicare program administered by the Secretary under Title XVIII of the Social Security Act. Pursuant to 42 U.S.C. § 1396a(a)(33)(B), the state health inspection agency ". . . will perform for the State agency administering . . . the plan . . . the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan . . . ." However, whenever the Secretary of HHS certifies a facility "to be qualified as a skilled nursing facility under Subchapter XVIII of this chapter, such institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of § 1396a(a)(28) of this title." 42 U.S.C. § 1396i. A facility may be certified as qualified to participate in the program, notwithstanding deficiencies, if the survey agency finds "that the facility's deficiencies, individually or in combination, do not jeopardize the patient's health and safety, nor seriously limit the facility's capacity to give adequate care" and if the survey agency "finds acceptable the facility's written plan for correcting the deficiencies." 42 C.F.R. § 442.105(a) and (b).

In addition to the survey and certification functions of the state health inspection agency, the Act imposes an additional quality of care mechanism which is at issue in this action, namely the requirement for a program of independent professional review of the adequacy of the services available to meet each Title XIX-assisted patient's health needs. 42 U.S.C. § 1396a(a)(31). Although the Act requires inspections of the adequacy of services, and the making of "full reports

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[1] In order to be certified as a skilled nursing facility for Medicaid purposes the facility must meet the requirements applicable to such facilities under Medicare. 42 U.S.C. § 1396a(a)(28). In order to be certified under Medicare as a skilled nursing facility, the facility must meet the requirements of state licensure (set by the state health inspection agency) and the additional conditions for participation in the program that are set in federal regulation at 42 C.F.R. § 405.1101-405.1137. 42 U.S.C. § 1395x(j).

to the state agency by each independent professional review team of the findings of each inspection under subparagraph (B) together with any recommendations," 42 U.S.C. § 1396a(a)(31)(C), there is *no* indication in the Act of the regulatory consequences that flow from adverse findings of patient review teams concerning the adequacy of care provided to individual patients.

The Court of Appeals, however, held that the judgment of the District Court requiring the termination of certified facilities based upon findings of inadequate care with respect to individual classmembers was "not precluded" of the Act. In doing so, however, the Court of Appeals refused to acknowledge the specific provisions in the Act linking a facility's participation to its certification by the state health inspection agency or the Secretary, 42 U.S.C. § 1396a(a)(33)(B), 42 U.S.C. § 1396i, which provisions are squarely inconsistent with the results reached below.

The Court of Appeals' affirmance of the judgment was apparently based, at least in part, upon its characterization of the judgment as being an appropriate exercise of discretion that does not require the termination of provider agreements, except for "irremediably noncompliant" facilities. Although the judgment does not require the Department "instantly to terminate a provider agreement," App. 21A, the fact remains that all other "corrective actions" listed in the judgment involve the filing of complaints with the state health inspection agency for whatever action that agency deems appropriate under state law. That agency is not a party to this proceeding and may not deem it appropriate to take action against a facility because of a failure to provide adaptive wheelchairs or related services. Furthermore, in light of the Court's findings on the recency of the development of the art of adaptive equipment, and on the limited availability of such equipment for disabled adults, it can hardly be said that a failure to provide such equipment or related services renders the facility "irremediably noncompliant."

Even accepting the Court of Appeals' characterization of the judgment, however, the question remains as to whether the Act authorizes the termination of provider agreements of facilities that are "irremediably noncompliant" with respect to the provision of adaptive wheelchairs and related services for individual Title XIX-assisted patients when the facility as a whole is determined to be qualified by the state health inspection agency or the United States Department of Health and Human Services. The bases articulated by the District Court and the Court of Appeals to uphold the requirement of termination of provider agreements simply do not withstand scrutiny.[2]

The District Court relied upon an ambiguous regulation that requires the single state agency to take "corrective action as needed." 42 C.F.R. 456.613. The Court ruled that "[w]hile 'corrective action' is not defined in the Medicaid Act or regulations, *it may reasonably be assumed* to include both informal requests for the SNF to correct the deficiencies, and more formal action such as cancellation or refusal to renew the SNF's provider agreement." App. 66A (emphasis added). However, the regulation requiring the single state agency to take "corrective action as needed" cannot be read in a manner that conflicts with the explicit statutory provisions linking a facility's participation to its certification. Furthermore, long-standing federal administrative interpretations of the pertinent regulation clearly contradict any such intent. In HEW, Medical Assistance Manual § 5-60-20, at p. 29, transmitted by MSA-PRG-25 (11/12/72), App. 103A, the Health Care Financing Administration only indicates that "corrective action" includes such informal steps as monitoring the facility's response to deficiency statements and filing complaints with the local medical society. The administrative interpretation indicates that even such informal steps "[o]rdinarily . . . would be done through the agency of the state responsible

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[2] As the petitioner indicated, *supra*, the Court of Appeals' unsupported conclusion that the judgment is "not precluded" by the Act is erroneous. 42 U.S.C. § 1396a(a)(33)(B) and 42 U.S.C. § 1396i expressly link a facility's participation to its certification.

under arrangements with the Title XIX agency for facility survey and consultation functions," *Id.*, (and not by the single state agency). Nowhere is it remotely suggested that the findings of patient review teams on individual patients constitute a basis for the termination of a certified facility.

The "good cause" exception of 42 C.F.R. § 442.12(d), which was primarily relied upon by the Court of Appeals, similarly does not justify termination of provider agreements for reasons related to the quality of care of individual patients. The general rule, linking the entry of provider agreements to the certification decisions of the state health inspection agency or the Secretary of the United States Department of Health and Human Services is stated in 42 C.F.R. 442.12(a) and (c). As an exception to the linkage of provider agreements to certification, the regulation authorizes the single state agency to terminate a provider agreement for "good cause."

The Court of Appeals rejected the argument of the petitioner that § 442.12(d)(1) is limited to reasons unrelated to quality of care, such as provider fraud and violations of civil rights requirements. In doing so, however, the Court of Appeals failed to acknowledge the explicit statutory provisions linking a facility's qualifications to participate in the program to the certification decision of the state health inspection agency or the Secretary of Human Services. 42 U.S.C. § 1396a(a)(33)(B), 42 U.S.C. § 1396i. The Court of Appeals further failed to acknowledge that the civil rights provision of 42 C.F.R. 442.12(d)(2) is illustrative of the reasons that may be employed to terminate agreements of qualified (certified) facilities under the "good cause exception" of 42 C.F.R. 442.12(d)(1). Finally, the Court of Appeals overlooked 42 C.F.R. § 489.12 which provides a similar good cause exception for the Secretary to terminate provider agreements of qualified (certified) facilities under the Title XVIII Medicare program. Given the clear linkages between skilled nursing facility participation in the Medicaid and Medicare programs, § 489.12

is highly instructive on the scope of the Medicaid good cause exception.[3]

The other bases relied upon by the Court of Appeals to uphold the judgment of the District Court similarly do not withstand analysis[4] Furthermore, repeated holdings of this Court and of the Courts of Appeals have recognized that whether or not a facility is qualified to participate is dependent upon its certification by the state health inspection agency or the Secretary. *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773 (1980); *Case v. Weinberger,* 523 F.2d 602 (2nd Cir. 1975); *Hathaway v. Mathews,* 546 F.2d 227 (7th Cir. 1976); *Geriatrics, Inc. v. Harris,* 640 F.2d 262 (10th Cir. 1981); *Bumpas v. Clark,* 681 F.2d 679 (9th Cir. 1982); *Town Court Nursing Center, Inc. v. Beal,* 586 F.2d 266 (3rd Cir. 1978); *Estate of Smith v. O'Halloran,* 747 F.2d 583 (10th Cir. 1984). The repeated holdings of these courts may not "squarely conflict" with the holding of the Second Circuit Court of Appeals in this action, since they concern the survey and certification requirements of 42 U.S.C. § 1396a(a)(33)(B) and 42 U.S.C. § 1396i, and not the inspection of care requirements of 42 U.S.C. § 1396a(a)(31); however, the holding that the findings of Departmental patient review teams with respect to individual patients constitutes a basis for the termination of provider agreements conflicts at least in principle with the prior holdings of this Court and of the various courts of appeals.

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[3] Of course, quality of care is of central concern to whether a facility may participate in both the Medicaid and Medicare programs. Under the Act, however, that quality of care determination is required to be made by the state health inspection agency or the Secretary of Health and Human Services as a result of their survey and certification functions, and not by the single state agency or the federal courts.

[4] The use of the disjunctive "or" in 42 C.F.R. § 431.151 setting out appeal procedures for the termination of "certification or a provider agreement" does not support a requirement that the petitioner terminate provider agreements because of deficiencies in care provided to a single patient. Furthermore, the single state agency principle, 42 U.S.C. § 1396a(a)(5), 42 C.F.R. § 431.10(e), does not authorize, or require, the federal courts or the single-state agency to substitute their judgment on whether a facility is qualified to participate for that of the state health inspection agency or the Secretary, which is stipulated for in the Act. 42 U.S.C. § 1396a(a)(33)(B); 42 U.S.C. § 1396i.

Furthermore, the ruling of the Court of Appeals raises issues of importance concerning the permissible scope of remedial relief that may be entered pursuant to legislation enacted under Congress' spending authority. Generally, the scope of remedial relief in any action must be tailored to address the found "violation of right." *Milliken v. Bradley*, 433 U.S. 267, 282 (1977); *Swan v. Charlotte Mecklenburg Bd. of Education*, 402 U.S. 1, 16 (1970). With legislation enacted pursuant to Congress' spending power, however, the states may not be required to implement all the "goals" or "objectives" of federal legislation, but may only be required to comply with mandatory conditions of participation in the program. *Quern v. Mandley*, 436 U.S. 725 (1978); *Beal v. Doe*, 432 U.S. 438 (1977). In addition, any condition of participation must be clearly and unambiguously expressed in order to be binding upon a state. *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17 (1981); *Middlesex County Sewage Authority v. National Sea Clammers Ass'n.*, 453 U.S. 1 (1981).

Sound public policy would indeed be enhanced if Congress authorized, or required, the states to take specified enforcement actions based upon the findings of patient review teams with respect to the adequacy of care provided to individual patients.[5] The petitioner is confident, however, that Congress would not authorize the draconian remedy of termination of provider agreements as a result of deficiencies in the care provided to individual patients when the facility as a whole is qualified to participate in the program. The Courts below, however, improperly require the Department to take such action against "noncompliant" but qualified facilities without any condition of participation (clearly stated or otherwise) which authorizes such relief, thereby substituting "judicial discretion" for the terms of the Act. As a result, the Department is enjoined to deny assistance to the elderly and infirm patients of any such facility—in violation of their statutory rights to receive assistance for the cost of care provided by the qualified facility of their choice. The granting of such relief in the absence of any clearly stated condition of participation requiring such action thereby raises issues of considerable importance justifying the granting of a writ of certiorari.

[5] Any enforcement action would more appropriately be taken by the state health inspection agency and not by the single state agency for purposes of administration. See 42 U.S.C. § 1396a(a)(9).

II. THE RULING OF THE COURT OF APPEALS RAISES ISSUES OF IMPORTANCE CONCERNING THE NATURE OF THE DETERMINATIONS THAT PATIENT REVIEW TEAMS ARE REQUIRED TO MAKE IN ACCORDANCE WITH 42 U.S.C. § 1396a(a)(31).

This action raises other issues of importance warranting the review of this Court in addition to the issue of whether the judgment requiring the termination of qualified, but noncompliant, facilities is authorized by the Act. The Act requires inspections by patient review teams with respect to each Title XIX-assisted person of the "adequacy of the services available to meet his current health needs and promote his maximum physical well-being." 42 U.S.C. § 1396a(a)(31). There is, of course, a considerable difference between a requirement that the single state agency inspect the adequacy of care provided by a facility and an affirmative obligation that the administering agency determine, for each Title XIX-assisted patient, that the services are adequate to meet his needs.

The Department acknowledged throughout this proceeding that its patient review teams do not customarily "second guess" the adequacy of the patient's plan of care that is developed on behalf of each patient by their personal physician. Both the District Court and the Court of Appeals held that by not reviewing the adequacy of the physician's plan of care, the Department could not fulfill its "obligation" of determining that the facility met each patient's health needs. However, the operative section of implementing regulations concerning the scope of the inspection of care obligation, 42 C.F.R. 456.610, does not require the single state agency to affirmatively determine that each patient's needs are met.

The Courts below erred by not recognizing that the scope of the single state agency's obligation to inspect the adequacy

of care is defined by § 456.610.[6] 42 C.F.R. § 456.610 reflects the assumption that quality care will result if the health care professionals who are most familiar with the patient attend to and address the patient's needs in a timely fashion, as evidenced by conducting medical evaluations, developing a plan of care, and making progress notes, which actions are documented in the medical records maintained by the facility. The role of the patient review team is essentially limited to ensuring that the responsible health care professionals attended to the needs of the patient as documented in the patient's medical records. 42 C.F.R. 456.610 does not require the teams to actually evaluate the patient's health status or "second guess" the adequacy of the physician developed plan of care.

The limited scope of patient review team inspections required by and § 456.610 is supported by § 456.602(g) and § 456.608. Pursuant to § 456.602(g), it is not required that a physician be a member of the patient review team (but only that a physician be available to provide consultation to the team). It would be most unreasonable to construe the applicable regulations as requiring a patient review team consisting of a nurse and a social worker (with a physician consultant) to "second guess" the adequacy of a physician developed plan of care—especially when the medical record reflects physician attentiveness to the needs of the patient.

Furthermore, § 456.608 specifies that the determinations of the teams must be based upon "(1) [p]ersonal *contact with and observation* of each recipient and (2) [r]eview of each recipient's medical record." A determination of whether the services provided are actually adequate to meet each patient's needs requires much more than mere personal contact with patients and a review of each patient's medical record.

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[6] The Court of Appeals erroneously held that the scope of the Department's obligations is not limited by § 456.610. App. 19A.

As a practical matter, the onerous requirement of the Courts below is impossible for the states to comply with. Even in a relatively small state, such as Connecticut, at any given time there are some seventeen thousand nursing home patients who receive Title XIX-assistance for the cost of care. The Department has neither the resources nor the expertise to review the treating physicians' plan of care in order to actually determine that each of these seventeen thousand Title XIX-assisted patients in Connecticut's nursing facilities is receiving services sufficient to meet his health needs. Certiorari should issue, therefore, for this Court to review the important question of the nature of the determinations that patient review teams are required to make.

III. THE REQUIREMENT THAT THE SINGLE STATE AGENCY INSPECT THE ADEQUACY OF CARE OF TITLE XIX-ASSISTED PATIENTS DOES NOT CREATE RIGHTS IN PROGRAM BENEFICIARIES THAT ARE ENFORCEABLE BY § 1983.

In *O'Bannon v. Town Court Nursing Center, supra*, this Court recognized that the Medicare and Medicaid Acts provide program beneficiaries with both direct and indirect benefits and held that only deprivations of direct benefits involve protected interests.

> In the Medicare and Medicaid programs the Government has provided needy patients with both direct benefits and indirect benefits. The direct benefits are essentially financial in character: the Government pays for certain medical expenses. . . .
>
> This case does not involve the direct benefits. Rather, it involves the Government's attempt to confer an indirect benefit on Medicaid patients by imposing and enforcing minimum standards of care on facilities like Town Court. When enforcement of those

> standards requires decertification of a facility, there may be an immediate adverse impact on some residents. But surely that impact, which is an indirect and incidental result of the Government's enforcement action, does not amount to a deprivation of any interest in life, liberty or property.

447 U.S. at 786–789.

Subsequently, in *Pennhurst, supra,* and in *Middlesex County Sewage Authority v. National Sea Clammers, supra,* p. 17, the Court indicated that:

> The Court . . . has recognized two exceptions to the application of § 1983 to statutory violations. In *Pennhurst State School and Hospital v. Halderman,* _____ U.S. _____ (1981), we remanded certain claims for a determination (i) whether Congress had foreclosed private enforcement of that statute in the enactment itself, and (ii) whether the statute at issue was the kind that created enforceable rights under § 1983.

In determining whether the statute creates the kind of rights enforceable under § 1983, the lower courts have analyzed a number of factors to ascertain legislative intent, including the factors identified in *Cort v. Ash,* 422 U.S. 66 (1975). *Crawford v. Janklow,* 710 F.2d 1321, 1326 (8th Cir. 1983) ("whether a particular federal statute creates substantive rights for the purposes of Section 1983 is a question similar to whether there is an implied cause of action directly under that statute.") Central to the determination of whether a § 1983 cause of action is available is not whether the statute creates an obligation upon the defendant in favor of the Secretary of Health and Human Services, but whether the statute also creates direct, personal rights in favor of private parties. *Beckham v. Housing Authority,* 755 F.2d 1074, 1077 (2nd Cir. 1985); *Keaakaha-Panaewa Community Ass'n. v. Hawaiian Homes Commission,* 739 F.2d 1467 (9th Cir. 1984); *Garrity v. Gallen,* 522 F. Supp. 171 (D.N.H. 1981).

Although numerous provisions in the Act create "entitlements" in program beneficiaries which have been held to be privately enforceable by § 1983, the courts have determined that various provisions of the Act do not create privately enforceable rights. *Bumpas v. Clark,* 681 F.2d 679, 683 (9th Cir. 1982) (42 U.S.C. § 1396a(a)(19) does not "create substantive rights in Medicaid recipients" — compliance "is a decision better left to the Department of Health and Human Services."). In accord, *Lynch v. Dukakis,* 719 F.2d 504 (1st Cir. 1983).

In *O'Bannon,* this Court held that the indirect benefit of quality of care inspections did not constitute a direct benefit involving protected interests. In accord, *see Fuzie v. Manor Care, Inc.,* 461 F. Supp. 689, 696-97 (N.D. Ohio 1977) where the Court ruled:

> Secondly, the Medicaid Act and the regulations contemplate administrative rather than judicial enforcement of the legislation's requirements. Participating providers' compliance with the requirements of the statute and regulations is monitored on both the federal and state levels . . . it is apparent that the creation of a private remedy would disrupt the implementation of the Medicaid Program. A private right of action, utilized to enforce specific limited portions of federal regulations on an ad hoc basis would circumvent the responsibility of the state to administer its plan . . . transferring the primary obligation in such cases from the administrative personnel intended to bear it to the federal courts.

Applying these principles, it is submitted that 42 U.S.C. 1396a(a)(31) places obligations upon the administering single state agency and holds it responsible to the Secretary of Health and Human Services. Such obligations, however, do not also constitute rights in program beneficiaries that are enforceable by § 1983. Alternatively, Congress appears to have foreclosed the availability of an implied cause of action by the

structure of the statute, including 42 U.S.C. § 1396b(g) and 42 C.F.R. § 456.650-456.657 which authorize a reduction in federal financial participation for a failure of a state to properly conduct independent professional reviews. The statutory remedy of reduction of federal financial participation may well be exclusive. *Pennhurst, supra; see, Colorado Dep't of Social Services v. Dep't of Health and Human Services,* 558 F. Supp. 337 (D. Col. 1983) (reducing federal financial participation because of deficient inspections by a state).

In this action the Courts in effect defined standards of acceptable care and enjoined the single state agency to enforce the judicially defined standards of care against skilled nursing facilities under pain of termination of provider agreements. This was done without the participation of both the state health inspection agency, which is required to establish and maintain standards of care,[7] and the skilled nursing facilities. It must be recognized that there is room for considerable differences of opinion as to what constitutes acceptable care. The Act, however, vests primary responsibility for establishing and maintaining acceptable levels of care with the state health inspection agency. 42 U.S.C. § 1396a(a)(9). By impliedly finding a § 1983 cause of action to enforce the inspection of care obligation, the courts and private litigants via § 1983 litigation have supplanted the administrative enforcement mechanisms provided in the Act. Furthermore, the courts improperly hold the single state agency responsible for maintaining quality of care in nursing facilities when the Act vests that responsibility with the agency with expertise in the area (the state health inspection agency). As a result, the single state agency is in the untenable position of defending the quality of care in nursing homes in private § 1983 litigation, when it is

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[7] The state health inspection agency is not only charged with the responsibility of determining whether or not nursing facilities are qualified to participate in the program. 42 U.S.C. § 1396a(a)(33)(B). It is also explicitly charged with the responsibility for ". . . establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services." 42 U.S.C. § 1396a(a)(9).

responsible neither for providing the care nor setting the standards of acceptable care. Furthermore, the single state agency is enjoined to take "corrective action," including termination of provider agreements, when it has no authority under state or federal law to take such action, notwithstanding that compliance with the order entered below will result in the denial of the right of all Title XIX-assisted patients in the facility to receive assistance for the care provided by the qualified provider of their choice. Accordingly, a writ of certiorari should be granted to review whether Title XIX-assisted patients have a § 1983 cause of action available to assert claims arising under 42 U.S.C. 1396a(a)(31) against the single state agency in order to resolve this issue of importance to the states.

CONCLUSION

For the foregoing reasons, this petition should be granted and a writ of certiorari issue to review the judgment and opinion of the Court of Appeals for the Second Circuit.

Respectfully submitted,

JOSEPH I. LIEBERMAN
Attorney General

HUGH BARBER
Assistant Attorney General
Counsel of Record

90 Brainard Road
Hartford, CT 06114
Tel. (203) 566-7098

Counsel for Petitioner

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

APPENDIX A:

DECISION OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT, DATED JUNE 30, 1986

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Nos. 853, 897—August Term, 1985

(Argued: March 10, 1986 Decided: June 30, 1986)

Docket Nos. 85-7900, -7908

DALE HILLBURN, by his parents and next friends Ralph and Eleanor Hillburn, JAMES CORBETT, by his next friend Roberta Reid, SANDRA FUCHS, by her mother and next friend Florence Fuchs, STEPHEN KAPLANKA and MARK KAPLANKA, by their mother and next friend Dorothy Napolitano,

Plaintiffs-Appellants-Cross-Appellees,

—v.—

EDWARD MAHER, Commissioner of the Connecticut Department of Income Maintenance, and NEW BROOK HOLLOW HEALTH CARE CENTER, INC.,

Defendants-Appellees,

EDWARD MAHER, Commissioner of the Connecticut Department of Income Maintenance,

Defendant-Appellee-Cross-Appellant.

Before:

KEARSE and CARDAMONE, *Circuit Judges*, and POLLACK, *District Judge.**

Appeal and cross-appeal from a judgment of the United States District Court for the District of Connecticut, Jose A. Cabranes, *Judge*, enjoining defendant Connecticut Department of Income Maintenance to ensure that "skilled nursing facilities" provide appropriate adaptive wheelchairs and related services for their resident Medicaid recipients, and to take "corrective action as needed" against skilled nursing facilities that fail to do so.

Affirmed.

DAVID C. SHAW, Hartford, Connecticut (Trowbridge, Ide & Greenwald, P.C., Shelley White, Hartford, Connecticut, on the brief), *for Plaintiffs-Appellants-Cross-Appellees.*

HUGH BARBER, Assistant Attorney General, Hartford, Connecticut (Joseph I. Lieberman, Attorney General, Hartford, Connecticut, on the brief), *for Defendant-Appellee-Cross-Appellant.*

* Honorable Milton Pollack, Senior Judge of the United States District Court for the Southern District of New York, sitting by designation.

PUBLIC INTEREST LAW CENTER OF PHILADELPHIA, Philadelphia, Pennsylvania (Frank J. Laski, Judith A. Gran, Philadelphia, Pennsylvania, of counsel), filed a brief *for Amicus Curiae The Association for Retarded Citizens, Connecticut.*

KEARSE, *Circuit Judge*:

Plaintiffs Dale Hillburn, *et al.*, recipients of aid under the Medicaid program, Title XIX of the Social Security Act ("Title XIX" or "Medicaid Act"), as amended, 42 U.S.C. §§ 1396-1396p (1982 & Supp. I 1983 & Supp. II 1984), who reside in "skilled nursing facilities" ("SNFs") in the State of Connecticut ("State"), appeal on behalf of themselves and a class of those similarly situated, from a final judgment entered in the United States District Court for the District of Connecticut after a bench trial before Jose A. Cabranes, *Judge*, granting the relief sought in their complaint to the extent of enjoining defendant Commissioner of the Connecticut Department of Income Maintenance (together "CDIM") to ensure that SNFs with which CDIM has Medicaid provider agreements provide appropriate adaptive wheelchairs and related services to members of the plaintiff class, and to take "corrective action as needed" against SNFs that fail to provide such wheelchairs and services. On appeal, plaintiffs contend principally that the district court's judgment is not broad enough and that the court should have considered plaintiffs' claims relating to essential programs other than adaptive wheelchairs and "order[ed CDIM] to implement the federal Medicaid law in Con-

necticut SNFs." CDIM cross-appeals, contending principally that the district court erred in finding its reviews of the care provided by SNFs inadequate, and that the injunction inappropriately requires CDIM to terminate its provider agreements with SNFs that fail to provide appropriate adaptive wheelchairs and related services even if the SNFs remain certified for participation in the Medicaid program by other regulatory bodies. We conclude that the injunction against CDIM was proper and that plaintiffs were not entitled to broader relief, and we accordingly affirm the judgment of the district court.

I. BACKGROUND

As the term is used in the Medicaid Act, an SNF is, essentially, an institution whose staff includes at least one registered professional nurse full time, whose policies are developed with the advice of a group of professional personnel including at least one physician, and which is engaged primarily in providing skilled nursing care and related services to resident patients who require medical or nursing care. *See* 42 U.S.C. § 1395x(j) (1982 & Supp. II 1984); *id.* § 1396a(a)(28). Plaintiffs were, at the time this suit was filed, disabled residents of SNFs in Connecticut. The principal defendant, and the only party against which the district court's judgment is directed, is CDIM, which is the single Connecticut agency responsible for administering the State's Medicaid plan.

CDIM itself does not provide health care services but enters into "provider agreements" with Connecticut SNFs that are certified to participate in the Medicaid program. The provider agreements, which are renewed yearly, state that the SNF will provide care and services in conformity with Title XIX and will meet the conditions of participa-

tion detailed in regulations promulgated by the United States Department of Health and Human Services ("HHS"), *see* 42 C.F.R. §§ 405.1101-405.1137 (1985).

Under the federal Medicaid laws, CDIM has two methods of making payment for SNF care: (1) payments to SNFs according to per diem rates for "skilled nursing facility services," as defined in 42 U.S.C. § 1396d(f) and 42 C.F.R. § 440.40(a) (1985), and (2) payments to suppliers for other Medicaid benefits. In general, CDIM pays SNFs for services rendered to Medicaid-eligible persons resident in such facilities principally on a per diem basis calculated with reference to the SNF's costs, which include expenditures not only for salaries, fees, supplies, staff training, and so forth, but also for equipment purchased by the SNF. Under this method of payment, CDIM's reimbursement of an SNF for a particular expenditure may take as long as 18 months. For certain equipment that may not fall within the definition of "skilled nursing facility services" (hereinafter "separate Medicaid benefits"), CDIM pays the supplier of the equipment directly, and the SNF incurs no cost.

An adaptive wheelchair is a piece of equipment designed to support and properly position the body of a disabled person; it is used for a person whose disabilities preclude the effective use of a standard wheelchair. An adaptive wheelchair must be designed with a particular individual in mind and is usually unsuitable for use by any other individual. Such wheelchairs have only recently become commercially available for adults and may be expensive to purchase and maintain.

A. *The Complaint and CDIM's Revision of Policy*

Prior to the commencement of this lawsuit in February 1982, CDIM's policy was to reimburse SNFs for the cost

of adaptive wheelchairs as part of their per diem rates rather than to pay the suppliers of such chairs directly. The thrust of plaintiffs' complaint was that this policy had resulted in SNFs' failing to provide needed adaptive wheelchairs to their disabled Medicaid-eligible residents because the cost was great and the delay in reimbursement too long. Contending that CDIM's policy therefore violated Medicaid regulations, plaintiffs sued on behalf of themselves and a class eventually certified as

> [a]ll Medicaid recipients residing in or admitted to Skilled Nursing Facilities in the State of Connecticut on or after February 18, 1982, who, under defendant's policies and practices, cannot obtain the adaptive wheelchairs necessary to maintain their health and insure their effective development.

Plaintiffs also complained that as SNF residents they were treated differently from Medicaid-eligible persons who did not reside in SNFs. For the latter group, CDIM paid the suppliers directly for needed adaptive wheelchairs. Plaintiffs contended that CDIM's policy of using only the per diem method of reimbursement for such chairs for Medicaid-eligible SNF residents thus discriminated against them in violation of § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1982 & Supp. II 1984), and the Equal Protection Clause of the Constitution.

The complaint principally sought injunctive relief requiring CDIM and SNFs to provide adaptive wheelchairs to members of the plaintiff class and to provide "related professional support services necessary to ensure that such adaptive wheelchairs are safely and properly used."

A five-day trial was held between December 17, 1982, and April 3, 1984, with substantial continuances on

consent of the parties in an effort to promote settlement. After several days of trial had been completed, CDIM amended its policy in October 1983 (and modified it further in February 1984), undertaking to make payment directly to suppliers for the cost of adaptive wheelchairs for Medicaid-eligible SNF residents.

In light of its amended policy, CDIM moved in November 1983 for dismissal of the complaint, contending that its new payment system rendered the action moot. The district court denied the motion. It concluded that since, under the new policy, SNFs were given the responsibility for identifying those SNF residents who needed adaptive wheelchairs and for monitoring their use, "[i]t cannot be said with assurance that the new policy will cause adaptive wheelchairs to be provided to all members of the plaintiff class."

With its motion to dismiss, CDIM filed a motion *in limine* seeking to exclude all future evidence at trial "concerning the care, habilitation or development of retarded persons residing in [SNFs] . . . unless such testimony is strictly limited to what professional services are required to 'adequately and safely use adaptive wheelchairs in nursing homes.' " The court stated that CDIM was perhaps attempting to tie plaintiffs too inflexibly to the language of the complaint, and it denied the motion without prejudice, noting that Fed. R. Civ. P. 1 provides that the Rules "shall be construed to secure the just, speedy, and inexpensive determination of every action," and that Fed. R. Civ. P. 8(f) provides that "[a]ll pleadings shall be so construed as to do substantial justice."

B. *Plaintiffs' Efforts To Broaden the Scope of the Action*

In June 1984, two months after the close of trial, plaintiffs moved to expand the definition of the plaintiff class in order to, *inter alia*, include in the class all persons who were or would be unable to obtain adaptive wheelchairs "as part of an overall therapeutic program that is necessary to maintain their health and insure their effective development." CDIM objected to this redefinition on the ground that it in effect sought to amend the complaint to expand plaintiff's claims into areas unrelated to adaptive wheelchairs; it argued that Fed. R. Civ. P. 15(b) did not authorize such a posttrial amendment of the complaint because these broader issues had not been tried with the express or implied consent of CDIM. The court denied plaintiff's motion to redefine the class insofar as it sought expansion of the class's substantive claims, noting that CDIM had "objected consistently to the introduction of evidence concerning programming to maximize the 'physical, mental and psychosocial functioning' of class members." The court expressly intimated no view as to the appropriateness of a properly filed motion to amend the complaint.

In October 1984, plaintiffs formally moved pursuant to Fed. R. Civ. P. 15(a) and (b) to amend the complaint, seeking principally to expand the action beyond the claims relating to adaptive wheelchairs and related services in order to demand "programming . . . to maximize the physical, mental and psychosocial functioning" of class members. After receiving extensive oral argument and briefing, the court observed that the motion had been inexplicably delayed, without permission, until long after the trial had ended and the case had been submitted to the court for decision; that CDIM had objected at trial to the

introduction of evidence relating to these broader issues and would be prejudiced by the amendment; and that the amendment might necessitate supplemental evidentiary proceedings. Concluding that "[r]e-opening discovery and trial of the action at this late date would not serve the interests of justice," the court denied the motion to amend the complaint.

C. *The District Court's Findings, Conclusions, and Judgment*

In a Memorandum of Decision dated July 17, 1985 ("Opinion"), the court ruled that plaintiffs were entitled to some relief, although most of their claims had been mooted by CDIM's new policy. First, the court found that adaptive wheelchairs are medical necessities for many severely disabled persons:

> 23. An adaptive wheelchair can be helpful in preventing the development of contractures. . . . Adaptive wheelchairs also reduce pain and discomfort caused by improper body positioning, and promote skin integrity by alleviating pressure points. . . . By providing appropriate body alignment, adaptive wheelchairs also facilitate safe and proper breathing, swallowing, and digestion. . . .
>
> 24. For many severely disabled persons, including some residents of SNFs, adaptive wheelchairs are a medical necessity. . . . Failure to provide an adaptive wheelchair can lead to deterioration of health and skills, and increases the risk of injury and death. . . .
>
> 25. An individual who needs an adaptive wheelchair and does not have one will not be able fully to

benefit from the physical therapy that is necessary to promote his health and physical well-being. . . . For this reason, some class members receive little or no needed physicial therapy. . . .

26. Many residents of SNFs who have been provided with adaptive wheelchairs have exhibited noticeable improvement as a direct result of using their adaptive wheelchairs. . . .

Opinion at 15-16. The court concluded that "the prescription of an adaptive wheelchair, like that of any necessary item of medical care, is a service that the SNF is required to provide as a condition of participation in the Medicaid program." *Id.* at 38.

The court held that insofar as plaintiffs had challenged CDIM's failure to pay suppliers directly for adaptive wheelchairs for Medicaid-eligible SNF residents, their claims were mooted by CDIM's 1983 amendment to its policy. The court decided, however, to construe the complaint as asserting also that CDIM had violated pertinent Medicaid standards by failing to ensure that SNFs properly (a) evaluated class members for appropriate adaptive wheelchairs and (b) provided appropriate services related to such wheelchairs. As thus construed, the complaint was not mooted by CDIM's new policy. Under that policy, the SNFs, not CDIM, had the responsibility for identifying SNF residents needing adaptive wheelchairs, performing interdisciplinary assessments of each resident's need, training their staffs in the safe and efficient use of such wheelchairs, and monitoring the residents who receive such chairs. The court noted that the costs incurred by SNFs in meeting these responsibilities would be reimbursed as part of their per diem rates, with the

usual delays, and hence there still might exist some disincentive for SNFs to seek adaptive wheelchairs for their residents who are Medicaid recipients.

The court concluded that CDIM had failed to comply with its obligations under federal law to ensure the adequacy of the SNFs' provision of such wheelchairs and services. It noted that CDIM is obligated by 42 C.F.R. §§ 456.600-456.614 (1985) to have medical review teams make periodic inspections of the adequacy of the care and programs provided by SNFs with which CDIM has provider agreements, and to have these teams report on "(1) 'the adequacy, appropriateness and quality of all services provided in the facility or through other arrangements, including physician services to recipients,' and (2) '[s]pecific findings about individual recipients in the facility.' 42 C.F.R. § 456.611." Opinion at 40. It noted further that CDIM is required to " 'take corrective action as needed based on the report and the recommendations of the team . . . .' 42 C.F.R. § 456.613." Opinion at 40.

The court found that, notwithstanding these requirements, CDIM's medical review teams made no effort to assess the appropriateness of the plan of care ordered by a physician for an SNF resident and hence CDIM could not properly evaluate the adequacy of care provided by SNFs. Thus, the court concluded that CDIM had failed to comply with its obligations under federal law to ensure the adequacy of the services provided by the SNFs with which it had provider agreements.

Accordingly, the court entered judgment against CDIM ("Judgment"), enjoining it principally

> (1) to ensure that its medical review teams, in the course of the required inspections of the adequacy of

care provided by SNFs, inspect and determine whether or not participating SNFs have (a) adequately evaluated class members' needs for adaptive wheelchairs, and (b) arranged for the provision of such chairs and for related services necessary to ensure the safe and adequate use of such chairs in SNFs for class members who require such services; and

(2) to "take corrective action as needed" if its medical review team finds that a participating SNF has failed adequately to assess the need for, provide, or provide needed services with respect to, adaptive wheelchairs for its resident Medicaid recipients.

The Judgment defines "corrective action as needed," which is not defined in the regulations, to "include[ ] those steps which [CDIM], or [its] designees, deem to be reasonable to ensure that [SNFs] provide adaptive wheelchairs and related services to class members, including, but not necessarily limited, to:" (1) consultation with the medical staff of the SNF, (2) requesting peer review by appropriate medical societies, and (3) filing complaints with appropriate State agencies such as the Connecticut Department of Health Services ("CDHS"), which could lead to the decertification of the SNF as a Medicaid provider. Judgment at 9-11.

Finally, the Judgment provides that if the corrective action taken or initiated by CDIM fails to remedy the failure of a participating SNF to provide an appropriate adaptive wheelchair, or related services necessary to ensure its safe and adequate use, to one or more Medicaid recipients residing in the facility, CDIM

> shall terminate the facility's provider agreement [with CDIM,] notwithstanding the fact that the facility is otherwise certified to participate in the Title XIX Medical Assistance Program by [CDHS] or [HHS] pursuant to the provision of 42 U.S.C. § 1396a(a)(9), 42 U.S.C. § 1396a(a)(33), 42 U.S.C. § 1396a(i), 42 U.S.C. § 1396i, 42 C.F.R. § 440.40 and 42 C.F.R. § 442.1-442.202, and there is no other basis in federal law (such as violation of civil right requirements) for a termination of the provider agreement.

Judgment at 12-13. The Judgment provides that any such termination "shall comply with the procedural requirements of federal law, including the requirements of notice and an opportunity for an administrative hearing by the facility. *See* 42 C.F.R. § 431.151-§ 431.154." Judgment at 13.

D. *Issues on Appeal*

Plaintiffs seek affirmance of the Judgment so far as it goes, but they have appealed, contending principally that the district court erred in granting them only narrow relief. They argue that the court should have (1) made a finding of fact that the health of class members had deteriorated as a result of their failure to receive adaptive wheelchairs, (2) issued a broad injunction requiring CDIM to "implement the federal Medicaid law in Connecticut SNFs," and (3) permitted them to amend the complaint to allege claims extending to programs and services other than those related to adaptive wheelchairs. CDIM has cross-appealed, contending principally that the district court erred (1) in finding that CDIM's reviews of SNF care have failed to meet federal Medicaid standards,

and (2) in enjoining CDIM to terminate its provider agreements with noncompliant SNFs that continue to be certified for Medicaid participation by HHS or CDHS.

For the reasons below, we find merit in none of the arguments advanced in support of the appeal or the cross-appeal. We turn first to the cross-appeal issues, to determine whether such relief as was granted was proper, and then to the appeal issues, to determine whether the denial of additional relief was proper.

II. CDIM's CONTENTIONS

The principal issues presented by CDIM's cross-appeal are whether the district court erred in ruling that the reviews conducted by CDIM's medical review teams failed to comply with Medicaid regulations, and whether the court could properly require CDIM to terminate its provider agreements with SNFs that fail to provide appropriate care for their Medicaid-eligible residents but continue to be certified by HHS or CDHS to participate in the Medicaid program. We find no clear error in the court's findings of fact, nor any misapplication of legal principles, nor any abuse of discretion in its fashioning of remedy.

A. *The Finding of Inadequate CDIM Review of SNF Care*

CDIM contends that the district court erred in ruling that the reviews of the care provided by SNFs conducted by CDIM's medical review teams failed to comply with federal law. We find no error.

The court found that although the evidence at trial was insufficient to show that the infrequency with which

CDIM reviews were conducted violated Medicaid regulations, the evidence was ample to show that the content of those reviews failed to meet the requirements of federal law. The court's findings of fact with respect to the substance of CDIM's reviews of the adequacy of the care provided by SNFs included the following:

> (1) that CDIM has entered into an agreement with CDHS which requires CDHS to perform periodic survey and certification inspections of SNFs participating in the Medicaid program. The purpose of these inspections is to determine whether such SNFs satisfy the conditions prescribed by HHS for participation in the program;
>
> (2) that the survey teams sent out by CDHS determine whether assessments prescribed by SNF physicians have been performed, whether a physician has approved a plan of care, and whether the plan of care is being executed; but they do not attempt to assess whether the plan of care ordered by the SNF physician is appropriate;
>
> (3) that if the CDHS review team finds deficiencies affecting the SNF population as a whole, they will prepare reports that could lead to the decertification of the SNF; but they do not report deficiencies that affect only a single SNF resident; and
>
> (4) that CDIM's own medical review teams also review physicians' orders for Medicaid recipients and determine whether the physician's orders are being executed; but they, like the CDHS survey teams,
>
> > do not attempt to assess the appropriateness of the physician's orders. . . . Accordingly, if the physician of an SNF resident has ordered that

> the resident be assessed for an adaptive wheelchair, [C]DIM's inspection teams determine whether the assessment has been conducted. If no assessment has been ordered by a physician, the teams do not attempt to determine whether the resident has been assessed for an adaptive wheelchair, or whether such an assessment would be appropriate.

Opinion at 23. The court found that if a CDIM review team finds a deficiency and the SNF fails to correct it, CDIM will discuss the matter with the SNF's administrators; but CDIM "takes no action to compel the SNF to correct the deficiencies." *Id.*

The court noted that 42 C.F.R. § 456.611 requires that a Medicaid agency's review team make "inspection reports [that] contain 'observations, conclusions and recommendations' concerning 'the adequacy, appropriateness and quality of *all services* provided in the facility . . . *including physician services* . . . [,]' 42 C.F.R. § 456.611 . . . ," Opinion at 41 (emphasis in Opinion), and that the agency is required to determine "whether the 'services available in the facility' are adequate 'to meet [each resident's] current health needs and promote his maximum physical well-being,' " *id.* at 42. It concluded that since CDIM's inspection teams did not, as a general matter, attempt to determine whether SNF residents have been properly evaluated for adaptive wheelchairs, CDIM was not providing the supervision of SNF health care required by federal law.

We find no error in the above findings of fact, and, indeed, CDIM, could hardly contend that they were erroneous: It entered into stipulations that squarely sup-

port them. Rather, CDIM contends that in seeking to determine what observations and evaluations CDIM's medical review teams were required by law to make, the court should not have looked to § 456.611 of 42 C.F.R., which is entitled "Reports on inspections," but rather should have looked to §§ 456.609 and 456.610, which are entitled, respectively, "Determinations by team," and "Basis for determinations." It argues that under the latter provisions, its reviews were not defective. This argument is poorly conceived and ill supported.

First, in stating the requirements for the contents of review team reports, § 456.611 can hardly be thought to require that the report be more extensive than the investigation; if the matter must be reported, it must first be investigated. Thus the court did not err in looking to § 456.611 for guidance as to the requirements for the contents of the investigation. Further, the sections relied on by CDIM do not show that review teams are not required to evaluate the adequacy, appropriateness, and quality of all services, including physician services. Section 456.610 sets forth a number of items the team "may" consider; it does not purport to state that there are no other items that the team should consider. Certainly such a list of possible considerations cannot be read as nullifying express statements in other sections as to what must be determined. Section 456.609 is even less helpful to CDIM, for both its language and its effect appear to have been recognized by the court. That section states that

> [t]he team must determine in its inspection whether—
>
> (a) The services available in the facility are adequate to—

(1) Meet the health needs of each recipient, . . . ; and

(2) Promote his maximum physical, mental, and psychosocial functioning.

Although the district court's opinion did not include a citation to § 456.609, the court's recognition that the review teams must "determine whether the 'services available in the facility' are adequate 'to meet [each resident's] current health needs and promote his maximum well-being,' " Opinion at 42, virtually recites the language of that section. And, as the court found, CDIM's team reviews could not meet these requirements: Since the team makes no attempt to determine whether it would have been appropriate to evaluate a given patient for an adaptive wheelchair—a device that is a medical necessity for some SNF residents—the team cannot determine whether the SNF's service, in light of its failure to make such an evaluation, was adequate to meet the health needs of the patient.

We conclude that the district court neither erred in its findings of fact nor failed to apply the correct legal standards, and that there is no basis for overturning its conclusion that CDIM's inspections did not comply with federal law.

B. *The Propriety of the Injunction Requiring CDIM To Terminate Its Provider Agreements With Irremediably Noncompliant SNFs*

CDIM also contends that the district court "clearly erred by ordering [CDIM] to terminate Title XIX provider agreements with SNFs based on the findings of [CDIM's] patient review teams on individual class mem-

bers when the facility is certified to participate in" the Medicaid program. In support of this challenge, CDIM points out that Title XIX "links nursing facility participation in the program to the certification decision of [CDHS] or [HHS]," that CDIM is not the agency that makes certification determinations, and that CDIM thus cannot be required to terminate its provider agreements with SNFs that are certified. We are unpersuaded.

First, as a practical matter, we note that CDIM appears to ignore the major thrust of the injunction entered against it. The Judgment does not require CDIM instantly to terminate a provider agreement upon the report of its review team that SNF care with regard to adaptive wheelchairs is inadequate. Rather, CDIM is enjoined to "take corrective action as needed" to attempt to remedy the deficiency. The Judgment defines "corrective action as needed" to include consultation by CDIM officials with the management of the SNF, the solicitation of peer review from medical societies, and the filing of complaints with other state agencies that could lead to the decertification of the SNF as a Medicaid provider. Only if the corrective actions taken or initiated by CDIM fail to induce the SNF to bring its services relating to adaptive wheelchairs into compliance with the law does the Judgment require CDIM to terminate its provider agreement with the SNF. The Judgment thus seems a prudent exercise of the district court's discretion, and we find nothing in the Medicaid scheme that prohibits it.

The fact that CDIM is not the agency responsible for certification of facilities as Medicaid providers is of no consequence. As the district court noted, the reason for the requirement that a state designate a "single State agency" to administer its Medicaid program, *see* 42

U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 431.1 and 431.10 (1985), was to avoid a lack of accountability for the appropriate operation of the program. *See generally* S. Rep. No. 404, 89th Cong., 1st Sess. (1965), *reprinted in* 1965 U.S. Code Cong. & Ad. News 1943, 2016-17 (suggesting that certain provisions of Medicaid bill were intended to achieve "simplicity of administration" and "assurance . . . that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided."). CDIM, as the single agency designated by Connecticut, retains the authority to "[e]xercise administrative discretion in the administration or supervision of the plan," and to "[i]ssue policies, rules, and regulations on program matters." 42 C.F.R. § 431.10(e). These regulations do not permit CDIM's responsibility to be diminished or altered by the action or inaction of other state offices or agencies. *Id.*

Nor does CDIM's argument that certification is required before CDIM may enter into provider agreements carry the day. Although CDIM is prohibited from entering into such agreements with SNFs that are not certified, *see, e.g.*, 42 C.F.R. § 442.12(a) (1985), we find nothing in the Medicaid scheme that requires CDIM to maintain a provider agreement with an SNF simply because it is certified. Indeed there are provisions that suggest precisely the contrary. Sections 431.151-431.154 of 42 C.F.R., for example, set out the appeal procedures that the state must make available to an SNF when the state has terminated "certification *or* a provider agreement for the Medicaid program," *id.* § 431.151 (emphasis added). Given that there can be no lawful provider agreement with a facility that is not certified, if the

provider agreement could not be terminated while a facility remained certified, the use of the disjunctive in § 431.151 *et seq.* would be meaningless.

More to the point of the substantive issue here, 42 C.F.R. § 442.12(d) (1985), as the district court noted, expressly allows the single state agency responsible for administering the Medicaid program to terminate, for good cause, a provider agreement with a certified SNF. That section provides as follows:

> (d) *Denial for good cause.* (1) If the Medicaid agency has adequate documentation showing good cause, it may refuse to execute an agreement, *or may cancel an agreement, with a certified facility.*
>
> (2) A provider agreement is not a valid agreement for purposes of this part even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

(Emphasis in text added.) CDIM contends that this provision does not authorize the district court's injunction that CDIM terminate provider agreements with SNFs as to which corrective action relating to adaptive wheelchairs has failed, because the section applies only to considerations unrelated to quality of care, such as civil rights requirements. We see no basis in law or in reason to find § 442.12(d)(1) so limited. The very purpose of the Medicaid program is to provide the needy with medical assistance, and many of Title XIX's provisions are plainly designed to enhance the quality of care that is provided. Certainly the language of the section does not suggest that poor quality health care cannot be good cause for termination; and if the provision of poor quality health care

cannot constitute good cause for the termination, the goal of the Medicaid program is thwarted.

Thus, we conclude that the Medicaid scheme did not preclude the relief fashioned by the district court. To the extent that a facility engaged to provide appropriate medical care fails to do so and cannot be persuaded to do so by such methods as consultation or the commencement of decertification proceedings, its provision of inadequate care and services may be found to constitute good cause for termination of the provider agreement. The Judgment's requirement that CDIM terminate its provider agreements with such recalcitrant SNFs was not improper.

We have considered all of the arguments advanced by CDIM in support of its cross-appeal and have found them to be without merit. We conclude that the Judgment of the district court is proper as far as it goes, and we turn now to plaintiffs' contentions that the Judgment did not go far enough.

III. PLAINTIFFS' CONTENTIONS

Plaintiffs, while urging us to affirm the Judgment to the extent that it grants them relief, contend that the district court should have granted broader relief in their favor, and they ask that we "remand this case to the district court with instructions to order the defendant to implement Subpart I of 42 C.F.R. part 456 [*i.e.*, §§ 456.600-456.614] fully and effectively." In support of their appeal, they contend (1) that the district court erred in failing to find that the health of class members had deteriorated for want of adaptive wheelchairs; (2) that their complaint as filed was broad enough to justify the granting of more extensive relief; and (3) that if the

complaint as filed was not broad enough, the court should have granted their motion to amend. We have considered all of plaintiffs' arguments in support of a broader judgment and find no merit in any of them.

A. *The District Court's Findings as to Injury*

In its assessment of the evidence at trial, the district court stated that

> it cannot be determined, on the basis of credible evidence in the record of this case, whether and to what extent the health of any particular class member has deteriorated since his admission into an SNF as a result of the SNF's failure to provide him with an adaptive wheelchair.

Opinion at 16. Plaintiffs contend that the "court's failure to make any finding in this respect is . . . clearly erroneous." Even if accepted, this contention provides no ground for a remand.

As detailed in Part I.C. above, the court found, *inter alia*, that adaptive wheelchairs were, for many severely disabled persons, a medical necessity that SNFs are required to provide. It found that CDIM's medical review teams did not adequately determine whether SNFs provided appropriate adaptive wheelchairs and related services to their Medicaid patients who need them. And on the basis of these findings, the court entered its Judgment enjoining CDIM to ensure that class members are properly evaluated for, provided with, and monitored for the safe and productive use of, appropriate adaptive wheelchairs.

We are hard pressed to see how an additional finding by the court that the failure of SNFs to provide adaptive

wheelchairs had actually caused harm to the health of particular class members would have resulted in the granting of any additional relief. Plaintiffs' complaint made no demand for damages; it requested injunctive and declaratory relief; and its requests were focused squarely on the provision of adaptive wheelchairs and services related thereto, *see* Part III.B. below. Much of the relief sought was forthcoming as a result of CDIM's post-complaint change of policy with respect to its method of payment for such wheelchairs; the remainder was granted by the Judgment that was entered. Thus, even were we to view as error the court's failure to make the finding requested by plaintiffs, we could not find that that failure resulted in any flaw in the Judgment.

B. *The Appropriate Breadth of the Relief*

We likewise find no merit in plaintiffs' contention that the district court should have enjoined CDIM generally to "implement the federal Medicaid law in Connecticut SNFs," or to take steps to ensure that SNFs provide appropriate programming and services for all the needs of class members, not just the needs relating to adaptive wheelchairs. The court appropriately tailored the relief to the issues that were properly before it.

As the district court noted,

> [i]n the early stages of this litigation, the dispute focused on [C]DIM's refusal to pay, as a separate Medicaid benefit, for adaptive wheelchairs for disabled residents of SNFs. All four counts of the Complaint, and all of the pretrial memoranda and proposed findings, address exclusively the issue of providing adaptive wheelchairs to class members.

Opinion at 6 (footnotes omitted). Plaintiffs' demands for relief were similarly focused. Aside from requesting costs, attorneys' fees, and "such further relief as the Court deems just," the complaint requested only that the court

> 1. Preliminarily and permanently enjoin the defendants to provide adaptive wheelchairs to handicapped persons living in nursing homes in Connecticut and any related professional support services necessary to ensure that such adaptive wheelchairs are safely and properly used.
>
> 2. Declare unconstitutional and unlawful under Section 5 of the Rehabilitation Act of 1973 the failure of defendants to provide adaptive wheelchairs to severely handicapped persons living in nursing homes.
>
> 3. Declare unconstitutional and unlawful under Section 5 of the Rehabilitation Act of 1973 the failure of defendants to provide treatment necessary to adequately and safely use adaptive wheelchairs in nursing homes.
>
> 4. Declare unlawful under the Social Security Act and regulations promulgated thereunder the refusal of the defendants to provide adaptive wheelchairs to handicapped persons living in nursing homes in Connecticut.
>
> 5. Declare unlawful under the Social Security Act and regulations promulgated thereunder the failure of the defendants to provide the related professional services necessary to adequately and safely use adaptive wheelchairs in nursing homes.

6. Preliminarily and permanently enjoin defendants to submit to plaintiffs and to the Court for its approval a plan to implement the aforesaid.

7. Enter an order certifying the class of persons plaintiffs represent to include all handicapped persons living in skilled nursing facilities in Connecticut who are, under defendants' policies and practices, ineligible for the adaptive wheelchairs necessary for their health and effective development.

8. Enter an order certifying the defendant class to include all skilled nursing facilities housing handicapped persons who need adaptive wheelchairs if thier [*sic*] health and developmental needs are to be properly addressed.

The district court noted that plaintiffs had attempted to expand their case midway through trial, "[perhaps] prompted in part by [C]DIM's amendment in October 1983—twenty months after the commencement of this suit—of its policy concerning adaptive wheelchairs." Opinion at 6. This attempted expansion took the form of efforts to introduce at trial, over CDIM's objection, evidence of inadequacy of SNF care unrelated to adaptive wheelchairs. The complaint was not amended. Indeed, as discussed in Part III.C. below, plaintiffs made no motion to amend the complaint until long after the trial had ended.

In the absence of a proper amendment to the complaint, the district court was fully justified in tailoring the relief granted to the demands set forth in the complaint.

C. *The Denial of the Motion To Amend the Complaint*

Finally, plaintiffs contend that if their complaint as filed was not sufficiently broad to warrant the granting of relief unrelated to adaptive wheelchairs, the district court was required to permit them to amend the complaint to state broader claims. We reject this contention.

As a general matter, "[t]he district court has discretion whether or not to grant leave to amend, and its decision is not subject to review on appeal except for abuse of discretion . . . ." 3 *Moore's Federal Practice* ¶ 15.08[4], at 15-64 (2d ed. 1985) (footnotes omitted); *see Foman v. Davis*, 371 U.S. 178, 182 (1962). In exercising its discretion, the district court is required to heed the command of Rule 15(a) to grant leave to amend "freely . . . when justice so requires." Fed. R. Civ. P. 15(a); *Foman v. Davis*, 371 U.S. at 182; 3 *Moore's Federal Practice* ¶ 15.08[4], at 15-65. Both this general principle and explicit guidelines for amendment of pleadings after the start of trial, provided in Rule 15(b), inform the district court's exercise of its discretion. Rule 15(b) provides as follows:

> (b) Amendments to Conform to the Evidence. When issues not raised by the pleadings are tried by express or implied consent of the parties, they shall be treated in all respects as if they had been raised in the pleadings. Such amendment of the pleadings as may be necessary to cause them to conform to the evidence and to raise these issues may be made upon motion of any party at any time, even after judgment; but failure so to amend does not affect the result of the trial of these issues. If evidence is objected to at the trial on the ground that it is not

> within the issues made by the pleadings, the court may allow the pleadings to be amended and shall do so freely when the presentation of the merits of the action will be subserved thereby and the objecting party fails to satisfy the court that the admission of such evidence would prejudice him in maintaining his action or defense upon the merits. The court may grant a continuance to enable the objecting party to meet such evidence.

The import of Rules 15(a) and (b) combined is that (1) a motion to amend the pleadings to conform them to the evidence may be made at any time; (2) if the motion is made during trial, either in response to an objection to evidence concerning issues not raised by the pleadings or without such an objection, it may be granted if the party against whom the amendment is offered will not be prejudiced by the amendment, and it should be granted in the absence of prejudice if the interests of justice so require; (3) if the motion is made after trial, and the issues have been tried with the express or implied consent of the parties, the motion must be granted; (4) if the motion is made after trial, and the issues have not been tried with the express or implied consent of the parties, the motion may be granted if the party against whom the amendment is offered will not be prejudiced by the amendment and should be granted in the absence of such prejudice if the interests of justice so require.

Within this framework, the district court's denial of plaintiffs' motion to amend the complaint was not an abuse of discretion. The court properly found that issues as to care unrelated to adaptive wheelchairs were not raised by the complaint and were not tried with the

consent of CDIM, either express or implied. Thus, the court was not required to allow the amendment unless it found there would be no prejudice to CDIM and that the amendment would be in the interests of justice.

The court found that the proposed amendment would have substantially altered and expanded the nature of plaintiffs' action and that CDIM would therefore be prejudiced by the proposed amendment since CDIM had called witnesses only to defend the issues framed by the complaint, *i.e.*, that in order to meet the health needs of the class members, SNFs were required to provide appropriate adaptive wheelchairs and the related support services necessary to ensure the safe and adequate use of such chairs. CDIM had presented no evidence with respect to other programs for class members "to maximize [their] physical, mental and psychosocial functioning." Thus, CDIM would be prejudiced by the posttrial amendment to introduce these broader claims. These findings were not erroneous, and the court's denial of the motion to amend on the ground that the amendment would prejudice CDIM was appropriate. *See, e.g., Browning Debenture Holders' Committee v. DASA Corp.*, 560 F.2d 1078, 1086 (2d Cir. 1977) (upholding denial of posttrial amendment that would have added a new claim, the issues as to which had not been tried).

The court also found that the interests of justice did not require that the amendment be allowed, noting, *inter alia*, that CDIM had objected to evidence on these expanded issues at trial, that plaintiffs had made no motion to amend the complaint during trial in response to these objections, and that they had delayed, without leave or explanation, until long after the trial ended and the case had been finally submitted to the court for decision, to

make their motion to amend. In all the circumstances, we conclude that the denial of plaintiffs' belated motion to amend the complaint in order to assert new and broader claims against CDIM was not an abuse of discretion.

CONCLUSION

The judgment of the district court is in all respects affirmed.

APPENDIX B:

ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT DENYING PETITION FOR REHEARING, DATED AUGUST 6, 1986

UNITED STATES COURT OF APPEAL
FOR THE SECOND CIRCUIT

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the sixth day of August one thousand nine hundred and eighty-six.

Present:

HON. AMALYA L. KEARSE,

HON. RICHARD J. CARDAMONE, Circuit Judges,

HON. MILTON POLLACK,* District Judge,

DALE HILLBURN, by his parents and next friends Ralph and Eleanor Hillburn, JAMES CORBETT, by his next friend Roberta Reid, SANDRA FUCHS, by her mother and next friend Florence Fuches, STEPHEN KAPLANKA and MARK KAPLANKA, by their mother and next friend Dorothy Napolitano,
Plaintiffs-Appellants-Cross-Appellees,

v.

EDWARD MAHER, Commissioner of the Connecticut Department of Income Maintenance, and NEW BROOK HOLLOW HEALTH CARE CENTER, INC.,
Defendants-Appellees,

UNITED STATES
COURT OF APPEALS
FILED
AUG. 6, 1986

Elaine B. Goldsmith, Clerk
Second Circuit

No. 85-7900, 7908

EDWARD MAHER,
Commissioner of the
Connecticut Department of
Income Maintenance,
Defendant-Appellee-
Cross Appellant.

A petition for a rehearing having been filed herein by defendant-appellee-cross appellant, Edward Maher, Commissioner of the Connecticut Department of Income Maintenance,

Upon consideration thereof, it is

Ordered that said petition be and it hereby is DENIED.

/s/ Elaine B. Goldsmith
Clerk

*Senior Judge of the United States District Court for the Southern District of New York, sitting by designation.

APPENDIX C:

MEMORANDUM OF DECISION OF THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF CONNECTICUT, DATED JULY 17, 1985

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

DALE HILLBURN, by his parents and next friends Ralph and Eleanor Hillburn; JAMES CORBETT, by his next friend, Robert Reid; SANDRA FUCHS, by her mother and next friend, Florence Fuchs; and STEPHEN KAPLANKA, and MARK KAPLANKA, by their mother and next friend Dorothy Napolitano	:	
v.	:	CIVIL NO. H 82-200 (JAC)
COMMISSIONER, Connecticut Department of Income Maintenance	:	

APPEARANCES:

DAVID C. SHAW
(Trowbridge, Ide & Greenwald)
Hartford, Connecticut

– and –

SHELLEY A. WHITE
(Connecticut Civil Liberties Union)
Hartford, Connecticut

– and –

JAMEY BELL
(Legal Aid Society of Hartford County)
Hartford, Connecticut

Counsel for Plaintiffs

JOSEPH I. LIEBERMAN
HUGH BARBER
MICHAEL A. ARCARI
(Office of the Attorney General)
Hartford, Connecticut

Counsel for Defendant

ALAN H. NEVAS
FRANK H. SANTORO[1]
(Office of the United States Attorney)
New Haven, Connecticut

MEMORANDUM OF DECISION

JOSÉ A. CABRANES, District Judge:

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I. INTRODUCTION

This is a class action for injunctive relief brought pursuant to Title XIX of the Social Security Act ("Title XIX"), which is popularly known as the Medicaid Act and is codified, as amended, at 42 U.S.C. §§1396-1397f. The plaintiffs are certain disabled Medicaid recipients living in skilled nursing facilities ("SNFs") in the state of Connecticut. The defendant is the Commissioner of the Connecticut Department of Income Maintenance ("DIM"), which is the state agency responsible for the administration of Connecticut's Medicaid plan.[2]

The Complaint (filed Feb. 18, 1982) describes the plaintiff class as "all handicapped persons who live in skilled nursing facilities in Connecticut who, [sic] are[,] under defendant's policies and practices, ineligible for the adaptive wheelchairs necessary for their health and development." Complaint ¶ 7. Pursuant to the court's orders of December 23, 1982 and September 19, 1984, the class currently is defined as follows:

> All Medicaid recipients residing in or admitted to Skilled Nursing Facilities in the State of Connecticut on or after February 18, 1982, who, under defendant's policies and practices, cannot obtain the adaptive wheelchairs necessary to maintain their health and insure their effective development.

See Ruling on Plaintiff's Motion to Amend Class Certification (filed Sept. 19, 1984) at 3.

According to the Complaint, this action was brought primarily to challenge DIM's policy, which was changed sometime after the filing of the Complaint, of refusing to provide Medicaid payment for adaptive wheelchairs for residents of SNFs. The plaintiffs' request for relief covers nine paragraphs. Briefly stated, the Complaint asks that this court, by injunction, require the defendant (1) to provide adaptive wheelchairs to members of the plaintiff class, and (2) to provide "treatment" and "related professional support services necessary to ensure that the adaptive wheelchairs are adequately and safely used." Complaint ¶¶ XI(1), XI(3). The plaintiffs also seek costs and attorneys' fees.

The Complaint states four grounds for the requested relief: (1) that adaptive wheelchairs are "prosthetic devices," which are optional items of coverage that Connecticut has elected to include in its Medicaid plan; (2) that since DIM will pay for adaptive wheelchairs for eligible handicapped persons who live outside of SNFs, its failure to pay for adaptive wheelchairs for members of the plaintiff class constitutes a violation of the Rehabilitation Act of 1973, 29 U.S.C. § 794; (3) that DIM's failure to provide adaptive wheelchairs to class members constitutes a violation of the Medicaid regulations; and (4) that DIM's disparate treatment of the plaintiffs and handicapped persons living outside of SNFs constitutes a violation of the Equal Protection Clause of the Fourteenth Amendment.

The complexity of the Social Security Act is the stuff of legend. The Supreme Court has offered the following lamentation on the subject:

> The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act "almost unintelligible to the uninitiated."

Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981), *quoting Friedman v. Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977). Further complicating this already difficult case was the effort of the plaintiffs' counsel, mid-way through trial, to shift the focus of the action from the plaintiffs' need for adaptive wheelchairs to the general lack of "programming" available in SNFs.[3] In the early stages of this litigation, the dispute focused on DIM's refusal to pay, as a separate Medicaid benefit, for adaptive wheelchairs for disabled residents of SNFs.[4] All four counts of the Complaint, and all of the pretrial memoranda and proposed findings, address exclusively the issue of providing adaptive wheelchairs to class members. *See* Plaintiffs' Pretrial Memorandum (filed May 3, 1982); Plaintiffs' Proposed Findings of Fact (filed May 3, 1982); Plaintiffs' Proposed Conclusions of Law (filed May 3, 1982). The plaintiffs' post-trial submissions focus on issues far afield of adaptive wheelchairs, and the plaintiffs apparently now see this case as a dispute

over the general inadequacy of "programming" for disabled residents of SNFs. *See* Plaintiffs' Post Trial Memorandum (filed June 21, 1984); Proposed Findings of Fact of the Individual Plaintiffs (filed June 21, 1984) ("Plaintiffs' Proposed Findings"); Plaintiffs' Proposed Conclusions of Law (filed June 14, 1984); Plaintiffs' Memorandum Concerning Jurisdiction and Class Certification (filed July 16, 1984).

The Plaintiffs' effort to expand their case may have been prompted in part by DIM's amendment in October 1983 – twenty months after the commencement of this suit – of its policy concerning adaptive wheelchairs. *See* Findings of Fact ¶¶ 36-48, *infra*. During the trial, the plaintiffs attempted, over the defendant's vigorous objections, to portray the case as one involving more than adaptive wheelchairs and the services necessary to ensure their safe and adequate use. However, the plaintiffs made no effort to amend their complaint until October 1984, more than six months after the conclusion of trial.[5] The plaintiffs' Motion to Amend Complaint (filed Oct. 15, 1984) was denied by a ruling filed on July 12, 1985. Accordingly, except where specifically noted in this ruling, the court considers only those claims identified in the pleadings and appropriately before the court now.

This action was tried to the bench over a period of five days beginning in December 1982 and concluding in April 1984. Final oral argument was heard on July 17, 1984, after the submission of post-trial memoranda and proposed findings of fact and conclusions of law. Lengthy recesses between trial dates were called to permit the parties to negotiate a settlement of the case. The parties' attempts to resolve the dispute prior to the conclusion of trial were unsuccessful.

Based on the full record of the case, the court concludes that the plaintiffs are entitled to no relief on the first, second, or fourth counts of the Complaint. The court today holds that DIM's policy governing the payment for adaptive wheelchairs for Medicaid recipients residing in SNFs is in full compliance with federal law. The court also holds that, contrary to the plaintiffs' contentions, DIM is not required by law to provide adaptive wheelchairs or related support services to class mem-

bers. Nor is DIM required to pay, as a separate Medicaid benefit, for support services related to the provision of adaptive wheelchairs to class members.

However, the plaintiffs have shown that DIM has failed to comply fully with certain obligations under federal law to identify and correct deficiencies in the care provided by SNFs to class members. The court finds that, to the extent these deficiencies concern the identification of SNF residents who require adaptive wheelchairs, the provision by SNFs of adaptive wheelchairs to class members, and the safe and adequate use of adaptive wheelchairs by class members, the plaintiffs are entitled to relief pursuant to count three of the Complaint.

Based on the full record of the case, including the evidence adduced at trial and the voluminous memoranda submitted by the parties, the court enters the following findings of fact and conclusions of law, pursuant to Rule 52(a), Fed. R. Civ. P.

II. FINDINGS OF FACT

A. State Participation in the Medicaid Program

1. Connecticut has chosen to participate in the federal-state Medicaid program authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1397f. Conn. Gen. Stat. § 17-134a; Stipulation (filed Jan. 12, 1984) (Stip.") ¶ 1.

2. In accordance with the federal Medicaid requirements, *see* 42 C.F.R. §§ 431.1 and 431.10, Connecticut has identified DIM as the "single state agency" or "state Medicaid agency" responsible for operating the state Medicaid program. Stip. ¶ 2.

3. DIM in turn has submitted a state Medicaid plan to the Health Care Financing Administration, Department of Health and Human Services ("HHS"), as required by 42 U.S.C. § 1396a(b). Stip. ¶ 2. This plan has been approved by HHS. *id.* In the plan, DIM, as the state Medicaid agency, promises to carry out the requirements of federal law in exchange for federal reimbursement of fifty percent of all qualifying services delivered under the program to eligible recipients. *Id.*

4. As the state Medicaid agency, DIM does not "provide" any services directly to Medicaid-eligible individuals. Certified Official Transcript of Proceedings Held December 17, 1982 (filed Jan. 5, 1983), January 7, 1983 and January 11, 1983 (filed Jan. 17, 1983), January 12, 1984 (filed Mar. 23, 1984), April 3, 1984 (filed Apr. 24, 1984) ("Tr.") at 992-993. No member of the plaintiff class resides in a facility operated by DIM. Rather, DIM pays participating medical providers for the cost of covered services provided to eligible individuals. *Id.*

5. In its capacity as the state Medicaid agency, DIM has entered into written "provider agreements" with each SNF that participates in the Medicaid program. Stip. ¶ 3. These provider agreements are renewed yearly.

6. The provider agreements state that the SNF will provide care and services in conformity with Title XIX, and will meet the conditions of participation detailed in HHS regulations, 42 C.F.R. §§ 405.1101-405.1137.[6]

7. In addition to paying for covered medical services provided to eligible individuals by participating providers, DIM has administrative responsibilities as the state Medicaid agency. These responsibilities are defined by federal law and are subject to federal oversight. Deposition of Stephen B. Heintz (filed Jan. 12, 1984) (Plaintiffs' Exhibit ("Pl. Ex.") 24) ("Heintz Dep.") at 8. Tr. 992-994, 1011-1013, 1037, 1041.

B. The Named Plaintiffs

8. When this action was commenced, the named plaintiffs, Dale Hillburn, James Corbett, Sandra Fuchs, Stephen Kaplanka and Mark Kaplanka, resided in SNFs in Connecticut. Tr. 94-95, 170, 404. Since that time, the Durham Convalescent Home, in which plaintiff James Corbett resides, has been renamed Dogwood Acres and designated as an intermediate care facility.[7] Tr. 385-386.

9. The other named plaintiffs still reside in SNFs. Dale Hillburn resides at the New Brook Hollow Health Care Center in Wallingford, Connecticut. Tr. 170. Mark Kaplanka, Stephen

Kaplanka and Sandra Fuchs reside at Lorraine Manor Nursing Home in Hartford, Connecticut. Tr. 94-95, 404.

10. The care and treatment of each of the named plaintiffs is paid for by DIM with funds appropriated under Title XIX. Tr. 94-95, 385-386, 404.

11. The named plaintiffs were placed in these SNFs by the Connecticut Department of Mental Retardation ("DMR") between 1976 and 1977. DMR, which is not a party to this action, retains some responsibility for each of the named plaintiffs. Tr. 384-385, 403-404.

12. Plaintiff Mark Kaplanka is mentally retarded and blind. He suffers from spastic quadraplegia, contractures (shortening of muscles due to disuse) of all extremities, dislocated hips, and scoliosis (curvature of the spine). Tr. 61-66, 98, 154-163. As a result of these conditions, he faces continuous risk of skin breakdown, impaired breathing, feeding difficulties, and aspiration pneumonia. *Id.* Plaintiffs Stephen Kaplanka, Sandra Fuchs, James Corbett, and Dale Hillburn all have medical difficulties of comparable severity. Tr. 95-101, 163-174, 387-391, 404-405, 409-410.

C. The Plaintiff Class

13. The named plaintiffs bring this action on their own behalf and on behalf of

> "Medicaid recipients residing in or admitted to Skilled Nursing Facilities in the State of Connecticut on or after February 18, 1982, who, under defendant's policies and practices, cannot obtain the adaptive wheelchairs necessary to maintain their health and insure their effective development."

See Ruling on Plaintiffs' Motion to Amend Class Certification (filed Sept. 18, 1984) at 3.

14. While all of the named plaintiffs are mentally retarded, not all of the class members are mentally retarded. Tr. 61-62, 952-958.

15. While the named plaintiffs were placed in SNFs by the DMR, many of the class members were admitted into SNFs by their families and not by the DRM. Tr. 953-958.

16. There are a minimum of 300 individuals in the plaintiff class. Tr. 61, 284, 965-966; Joint Exhibit ("Jt. Ex.") 12.

D. DIM's Methods of Payment to SNFs

17. DIM pays for SNF services[8] rendered to Medicaid-eligible persons through the use of scheduled rates set by HHS under the authority of 42 U.S.C. § 1396a(a)(13)(A). The rates for payment of SNF services are calculated in the following manner:

a. At the beginning of each fiscal year, each SNF submits to DIM a statement of its costs for the previous fiscal year. Deposition of Stephen Press (filed Jan. 12, 1984) (Pl. Ex. 22) ("Press Dep.") at 40-43, 93-96, 122-123; Heintz Dep. at 43-45. The costs submitted include expenditures for equipment and supplies, salaries of staff members and consultants, staff training, and other expenses. *Id.* DIM disallows certain non-reimbursable expenditures, such as advertising. *Id.*

b. The total allowable costs for the previous year are adjusted upwards to account for anticipated inflation. *Id.* This adjusted figure is used to calculate the following year's rate. *Id.* That rate provides for a fixed reimbursement per resident, per day, and is known as the *per diem* rate. *Id.*; Tr. 136.

c. The calculation of the *per diem* rate is performed by an accounting firm under contract with DIM. Press Dep. at 41.

18. Under this system, reimbursement for a particular expenditure may take up to 18 months., Stip. ¶ 7; Heintz Dep. at 43. Due to this delay in reimbursement, some financial disincentive may exist for an SNF to make costly expenditures. However, there is no credible evidence in the record of this case from which the court can ascertain the degree of the

disincentive, much less whether any such disincentive would raise questions of law. Likewise, no credible evidence in the record permits the court to make a determination of the effect of any such disincentive upon the provision of adaptive wheelchairs to residents of SNFs.

19. A cost-based reimbursement system resulting in *per diem* rates for the cost of services is the standard method of payment for health care employed in the United States. Tr. 999-1000. It is the method employed by most insurance companies and by the United States in its administration of the Medicare Program, 42 U.S.C. § 1395-1395xx. *Id.*

20. The cost of some equipment provided to residents of SNFs is paid by DIM directly to the suppliers of the equipment. The cost of this equipment is paid separately because it does not fall within the definition of "skilled nursing facility services." Because the SNFs do not pay for this equipment, these costs are not reflected in the *per diem* rate.

E. Adaptive Wheelchairs

21. An adaptive wheelchair is a piece of equipment designed to support and properly position a disabled person's body. Tr. 86-88, 924, 930. Adaptive wheelchairs are used for persons whose disabilities preclude the effective use of standard wheelchairs. *Id.*

22. Adaptive wheelchairs for residents of SNFs must be designed with the resident in mind. Tr. 57-58, 193-194, 499. The greater an individual's disability, the more adaption a wheelchair for that individual is likely to require. Tr. 924, 930. An adaptive wheelchair manufactured for one individual cannot be expected to be used for any other individual. Tr. 106, 196-197, 925.

23. An adaptive wheelchair can be helpful in preventing the development of contractures. Tr. 62-64, 88, 154-156, 173-174; *see* ¶ 12, *supra.* Adaptive wheelchairs also reduce pain and discomfort caused by improper body positioning, and promote skin integrity by alleviating pressure points. Tr. 150-160, 390-391, 454-455. By providing appropriate body

alignment, adaptive wheelchairs also facilitate safe and proper breathing, swallowing, and digestion. Tr. 88, 160-161, 174-178, 400-403, 925-933.

24. For many severely disabled persons, including some residents of SNFs, adaptive wheelchairs are a medical necessity. Tr. 925-933. Failure to provide an adaptive wheelchair can lead to deterioration of health and skills, and increases the risk of injury and death. Tr. 289, 519, 644, 854.

25. An individual who needs an adaptive wheelchair and does not have one will not be able fully to benefit from the physical therapy that is necessary to promote his health and physical well-being. Tr. 92-94, 564-566. For this reason, some class members receive little or not needed physical therapy. *Id.*

26. Many residents of SNFs who have been provided with adaptive wheelchairs have exhibited noticeable improvement as a direct result of using their adaptive wheelchairs. Tr. 84-85, 90-94, 400-401.

27. Notwithstanding the established medical benefits to be gained from the use of an adaptive wheelchair by certain disabled persons, it cannot be determined, on the basis of credible evidence in the record of this case, whether and to what extent the health of any particular class member has deteriorated since his admission into an SNF as a result of the SNF's failure to provide him with an adaptive wheelchair.

28. The cost of an adaptive wheelchair varies depending on its complexity. Tr. 108.

29. Adaptive wheelchairs require periodic repairs due to wear and tear, and they require adjustments or modifications due to changes in the condition of the individual using the wheelchair. Tr. 106-107, 940-941.

30. Only in the last five years have commercial adaptive wheelchairs for severely impaired adults become available. Tr. 890, 926. Adaptive wheelchairs for severely disabled adults are still not widely available commercially. Tr. 447-448, 737, 925-931. SNFs seeking to provide adaptive wheelchairs for

their residents may have some difficulty in obtaining appropriate adaptive wheelchairs. *Id.*

31. There is no evidence in the record supporting the plaintiffs' claim that an adaptive wheelchair is a "prosthetic device" as that term is defined in 42 C.F.R. § 440.120(c).[9] Credible evidence in the record suggests that an adaptive wheelchair is not a prosthetic device. *See* Tr. 955-956, Press Dep. at 103.

F. Related Services Necessary to Ensure the Safe and Adequate Use of Adaptive Wheelchairs in SNFs

32. The initial step in the provision of an adaptive wheelchair to a resident of an SNF would be an appropriate assessment by a physical therapist and physician. Tr. 196, 931.

33. Because an adaptive wheelchair for an SNF resident must be designed with the resident in mind, *see* ¶ 22, *supra*, a physical or occupational therapist must participate in the design and construction of an adaptive wheelchair. Tr. 106, 196-197, 862, 931.

34. For adaptive wheelchairs to be properly used in an SNF, the SNF's staff must be trained in the use and routine maintenance of adaptive wheelchairs. Tr. 195-196, 936. The resident using the adaptive wheelchair must be monitored closely by physicians, therapists, and other attendants for his tolerance to the chair and for physical changes as a result of using the chair. Tr. 936. These services are necessary to ensure the physical well-being of the user. Tr. 954.

35. A 24-hour per day "positioning plan" should be developed for each user of an adaptive wheelchair. Tr. 938.

G. DIM's Policy on Adaptive Wheelchairs

36. When the trial of this action began, DIM's policy was not to pay for an adaptive wheelchair, as a separate Medicaid benefit, on behalf of a resident of an SNF. Jt. Ex. 21, 24, 25; Tr. 944-945; *see* ¶ 20, *supra*. DIM would, however, pay for the

cost of an adaptive wheelchair provided by an SNF by including the cost in the calculation of the SNF's *per diem* rate. *Id; see* ¶ 17, *supra.*

37. At the same time, *see* ¶ 36, *supra*, it was the policy of DIM to pay for the cost of an adaptive wheelchair, as a separate Medicaid benefit, based on a determination of medical necessity, for applicants living outside of an SNF. Payment for the wheelchair was made by DIM directly to the supplier. Press Dep. at 38, 40, 86, 89, [illegible] 8.

38. At the same time, *see* ¶¶ 36, 37, *supra*, DIM would also pay for the cost of an adaptive wheelchair, as a separate Medicaid benefit, based on a determination of medical necessity, for residents preparing to leave an SNF. Payment for the wheelchair was made by DIM directly to the supplier. The costs incurred by the SNF in training the recipient and his family members in the operation of the wheelchair were reimbursed through the SNF's *per diem* rate. *Id.*

39. Pursuant to this policy, *see* ¶¶ 36-38, *supra*, DIM denied applications submitted on behalf of named plaintiffs Dale Hillburn and James Corbett, *see* ¶¶ 8-9, *supra*, for payment, as a separate Medicaid benefit, for adaptive wheelchairs. Pl. Ex. 14; Jt. Ex. 22, 23; Tr. 396-397, 407-409.

40. Except for the applications for payment submitted in behalf of Dale Hillburn and James Corbett, presented by Pelton's Surgical Supply and Adaptive Therapeutics, respectively, no suppliers of medical equipment have requested DIM to authorize payment for adaptive wheelchairs for any other members of the plaintiff class. Tr. 530.

41. DIM's policies as amended October 1, 1983, Jt. Ex. 33, and subsequently modified, effective February 1, 1984, Jt. Ex. 46, 47, 48, allow for the direct payment to a medical equipment supplier for the cost of an adaptive wheelchair for an SNF resident. Tr. 945; *see* ¶¶ 36-39, *supra.*

42. The amended DIM policies place on the SNF the responsibility for the identification of SNF residents needing adaptive wheelchairs. Tr. 973. The amended DIM policies

require the SNF to perform or obtain an interdisciplinary assessment of a resident's need for an adaptive wheelchair prior to DIM's authorization for payment. Jt. Ex. 46, 47, 48; Tr. 945-946. The assessment must be conducted by the resident's physician, an orthopedist, and a physical or occupational therapist. *Id.* The assessment process must also include the evaluation of recent X-rays. *Id.* The SNF is responsible for assembling the interdisciplinary team, and the SNF is required to pay for the costs of all professionals included on such teams. Stip. ¶ 7; Jt. Ex. 46, 47, 48; Tr. 811, 973-975, 977. These costs are reimbursed through the SNF's *per diem* rate. *Id.*

43. The amended DIM policies require that SNF staff members receive training in the safe and efficient use of adaptive wheelchairs. Stip. ¶ 7; Jt. Ex. 46, 47, 48; Tr. 973-975, 977. The cost of staff training is reimbursed through the SNF's *per diem* rate. *Id.*

44. The amended DIM policies require that SNFs perform periodic monitoring of residents who receive adaptive wheelchairs. The monitoring costs are reimbursed through the SNF's *per diem* rate. *Id.*

45. Since certain costs associated with the provision of adaptive wheelchairs continue to be reimbursed through the SNF's *per diem* rate, *see* ¶¶ 42-44, *supra*, some financial disincentive may exist for SNF administrators to obtain adaptive wheelchairs for the residents of their facilities. *See* ¶ 18, *supra*. Neither the degree of this disincentive nor its effect on the provision of adaptive wheelchairs to SNF residents can be ascertained on the basis of credible evidence in the record of this case.

46. DIM has hired an expert in the field of adaptive equipment, Julie Pollard, to assist in the implementation of its revised policies. Jt. Ex. 49.

47. DIM has recommended to SNF administrators that SNFs lacking personnel with experience in adaptive equipment should retain consultants to assist in the evaluation of residents' needs for, and the provision of, adaptive wheelchairs.

Id.; Tr. 956. A list of names of possible consultants has been provided to facilities by DIM's adaptive equipment consultant. Tr. 957.

48. DIM's amended policies have been explained to SNF administrators and suppliers of durable medical equipment during three workshops in various locations around the state. Tr. 974-949. The policies have also been explained to representatives of the DMR, to DIM patient review teams, and to the Association of Nursing Home Administrators. *Id.*

H. Compliance with Certification and Inspection Requirements

49. Connecticut's state health agency is the Connecticut Department of Health Services ("DHS"). Pursuant to the requirements of 42 U.S.C. § 1396a(a)(33)(A), DIM has entered into an inter-agency agreement with DHS. Stip. ¶ 5; Jt. Ex. 32; Tr. 994. This agreement requires DHS to perform periodic survey and certification inspections of SNFs participating in the Medicaid program. *Id.*

50. The purpose of these inspections is to determine if participating SNFs satisfy the conditions prescribed by HHS for participation in the program, 42 C.F.R. §§ 405.1121-405.1137.

51. In its inspections of SNFs, *see* ¶¶ 49-50, *supra*, DHS surveyors use a survey document prescribed by HHS entitled "Medicare/Medicaid Skilled Nursing Facility Survey Report." Defendants' Exhibit ("Def. Ex.") 51.

52. As part of the survey and certification process, DHS survey teams determine whether assessments prescribed by SNF physicians have been performed, whether a physician has approved a plan of care, and whether the plan of care is being executed. Stip. ¶ 5(d). The survey teams do not attempt to assess the appropriateness of the plan of care ordered by a resident's physician. *Id.*

53. Based on the results of these inspections, DHS makes decisions concerning the certification of SNFs and mails

copies of the decisions to DIM. Stip. ¶ 5(e), (f). DIM enters into "provider agreements" only with those SNFs certified by DHS. Tr. 999-1000.

54. If DHS surveyors find deficiencies, they will prepare a deficiency report. Deficiency citations are made only for deficiencies affecting the population of the SNF as a whole. Stip. ¶ 5(c). No deficiency that affects only a single resident will be cited by the DHS surveyors in a deficiency report. *Id.*

55. Proceedings to decertify SNFs in Connecticut have been initiated by both DHS and HHS. Tr. 1011-1012. DIM does not initiate proceedings to decertify SNFs. *Id.*

56. DIM's own inspection teams also make periodic inspections of SNFs to determine if Medicaid recipients are receiving appropriate care. Stip.¶ 4.

57. DIM's inspection teams known as patient review teams, review the physician's orders for each Medicaid recipient and determine whether the physician's orders are being executed. *See also* ¶ 52, *supra.* The teams do not attempt to assess the appropriateness of the physician's orders. Stip. ¶ 4(c); *see also* ¶ 52, *supra.* Accordingly, if the physician of an SNF resident has ordered that the resident be assessed for an adaptive wheelchair, DIM's inspection teams determine whether the assessment has been conducted. If no assessment has been ordered by a physician, the teams do not attempt to determine whether the resident has been assessed for an adaptive wheelchair, or whether such an assessment would be appropriate. *Id.*

58. Deficiencies are noted in the inspection teams' reports, *see* ¶¶ 52, 57, *supra,* and made known to the SNF and DHS. Stip. ¶ 4(e). If an SNF fails to correct its deficiencies, DIM will discuss the matter with the SNF's administrators. DIM takes no action to compel the SNF to correct the deficiencies. DIM will not cancel the SNF's provider agreement as a result of an SNF's failure to correct deficiencies. *Id.*

III. CONCLUSIONS OF LAW

A. Federal Statutory Scheme

Title XIX and the federal regulations promulgated thereunder establish a comprehensive system of health care for the needy. In the spirit of "cooperative federalism," *King v. Smith*, 392 U.S. 309, 316 (1968), Congress annually appropriates funds to enable each state, "as far as practicable under the conditions in such State," to furnish "medical assistance" to designated families with dependent children and to aged, blind, or disabled individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396.

A state is not required to participate in the Medicaid program. If it elects to participate, a state receives partial federal reimbursement for all qualifying services delivered under the program to eligible persons. *See* 42 U.S.C § 1396d(b). To become a participant, a state must submit a plan for medical assistance to HHS for approval; approval is conditioned upon the plan conforming to the provisions of Title XIX. *See* 42 U.S.C. §§ 1396, 1396a(b). Thereafter, operation of the program is primarily under state direction, with continuing eligibility for federal funds subject to the state's compliance with the originally approved plan and applicable federal regulations. *See* 42 U.S.C. § 1396c; 45 C.F.R. §§ 246-280. Once a state elects to participate in the Medicaid program, it must comply with federal law governing the program. *Harris v. McRae*, 448 U.S. 297, 301 (1980).

Title XIX divides potential recipients into the "categorically needy," *see* 42 U.S.C. § 1396a(a)(10)(A), and the "medically needy," *see* 42 U.S.C. § 1396a(a)(10)(C).[10] An approved state Medicaid plan must provide for medical assistance to the "categorically needy" with respect to six general areas of medical treatment: (1) in-patient hospital services, (2) outpatient hospital services, (3) other laboratory and x-ray services, (4) skilled nursing facility services, (5) physicians' services, and (6) nurse-midwife services. 42 U.S.C. §§ 1396a(a)-(10)(A), 1396d(a)(1)-(5), (17). A participating state need not "provide funding for all medical treatment falling within the

[six] general categories." *Beal v. Doe*, 432 U.S. 438, 441 (1977). However, the state plan must "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . are consistent with the objectives of [Title XIX]." 42 U.S.C. § 1396a(a)(17).

A state may decide to limit coverage to the "categorically needy," or it may decide to include within the scope of its Medicaid program the "medically needy." A state whose medical assistance program extends to the "medically needy" has the option of providing all of the services made mandatory as to those in the "categorically needy" class, or selecting any seven of some seventeen enumerated services (which include the group of six categories of medical treatment noted above). *See* 42 U.S.C. §§ 1396a(a)(13), 1396d(a)(1)-(17).

Furthermore, any medical services made available to a "categorically needy" person must not be less in "amount, duration, or scope" than that provided to other groups or individuals. 42 U.S.C. § 1396a(a)(10)(B). Services made available to the "medically needy" must be equal in "amount, duration, and scope" for all individuals classified as "medically needy," but may be less than or different from the benefits furnished to the "categorically needy." *Id.*

A state seeking approval of its Medicaid plan must establish or designate a "single state agency" or "state Medicaid agency" to administer or supervise administration of its plan. 42 U.S.C. § 1396a(a)(5). That state agency is responsible for contracting with institutions such as SNFs to provide services to persons eligible for assistance under Medicaid. The state Medicaid agency also must arrange for the state health agency to establish and maintain health standards for all private and public institutions in which Medicaid recipients receive care or services. 42 U.S.C. § 1396a(a)(9)(A). The state Medicaid plan must describe these standards as well as the standards and methods the state will use to assure that medical care and services provided to Medicaid recipients "are of high quality." 42 U.S.C. § 1396a(a)(22)(A), (D).

Title XIX requires the state Medicaid plan to provide that SNFs receiving payments under the plan must comply with

all of the requirements contained in 42 U.S.C. § 1395x(j), which defines "skilled nursing facility" for purposes of the Medicaid Act.[11]

B. Effect of 1983 Amendment to DIM's Adaptive Wheelchair Policy

At the time this lawsuit was filed, DIM's policy was to pay for adaptive wheelchairs, as a separate Medicaid benefit, only for persons living outside of an SNF. DIM's position at that time was that the cost of an adaptive wheelchair for a resident of an SNF should be borne by the SNF and reimbursed through the facility's *per diem* rate. *See* Findings of Fact ¶¶ 36-39.

On October 1, 1983, DIM amended its policies to allow for a direct and separate Medicaid payment to suppliers of adaptive wheelchairs on behalf of residents of SNFs. The current practice is to pay for adaptive wheelchairs, as a separate Medicaid benefit, for any resident of an SNF for whom such equipment is prescribed by a SNF physician following an interdisciplinary assessment. *See* Findings of Fact ¶¶ 41-48.

The effect of this amendment was to moot some, though not all, of the claims raised in the Complaint.[12] To the extent that the Complaint seeks to have this court order DIM to *pay* for adaptive wheelchairs for residents of SNFs, the claim for relief is moot. *See Abrams v. Interco Inc.*, 719 F.2d 23, 31-34 (2d Cir. 1983) (Friendly, J.) (holding that district court properly dismissed action where defendant's settlement offer gave plaintiffs the relief they requested); 13A Wright, Miller & Cooper, *Federal Practice and Procedure* §3533.2, at 236-240 (rev. 2d ed. 1984). However, the Complaint also sought to have this court order DIM to *provide* adaptive wheelchairs to members of the plaintiff class and to provide "treatment" and "related professional support services." Since DIM's current policy vests with the SNF the responsibility for deciding whether to provide an adaptive wheelchair and for providing related professional support services, DIM's current policy does not grant plaintiffs all the relief sought in the Complaint.

In the wake of the amended policy, the court need not dwell on the first claim of the Complaint. The first claim states that adaptive wheelchairs are "prosthetic devices," which are optional items that Connecticut has elected to include in its Medicaid plan. The plaintiffs have failed to demonstrate that adaptive wheelchairs are "prosthetic devices." *See* Findings of Fact ¶ 31.

Even if it is assumed for the argument that adaptive wheelchairs are "prosthetic devices," the plaintiffs would not be entitled to the relief that they seek. It is undisputed that Connecticut is obligated only to reimburse medical equipment suppliers for prosthetic devices supplied to eligible persons. Plaintiffs nowhere argue that DIM is obligated by law to *provide* such devices to eligible persons. Nor is DIM obligated to provide, in addition to its *per diem* payments to the SNFs, any related professional support services to residents of SNFs for whom prosthetic devices are prescribed.

Since DIM's adaptive wheelchair policy no longer provides for disparate treatment for residents and non-residents of SNFs, the second and fourth counts of the Complaint must also fail.[13] In count two of the Complaint, the plaintiffs contend that the disparate treatment is a violation of the Rehabilitation Act of 1973, 29 U.S.C. § 794. Count four states that the disparate treatment is a violation of the Equal Protection Clause of the Fourteenth Amendment. The court need not reach these questions, inasmuch as it is uncontested that DIM's amended policy concerning adaptive equipment places residents and non-residents of SNFs on the same footing. Because counts two and four provide no support for the plaintiffs' demand for the actual provision of adaptive wheelchairs to class members, or for the provision of related professional support services, these claims must fail.

C. Remaining Statutory Claim

The only remaining count in the Complaint is the claim that DIM's failure to provide adaptive wheelchairs to class members violates the Medicaid regulations. The stated objective of the Medicaid Act is to help eligible recipients to "attain and retain independence and self-care." 42 U.S.C. § 1396.

However, it is settled that a state is not required to implement all of the objectives of the Medicaid Act and may be required to provide only those services that are mandatory on the state as a condition of participation. *Beal v. Doe, supra,* 432 U.S. at 447 (1977); *see Pennhurst State School and Hospital v. Halderman,* 451 U.S. 1, 27 (1981). Because the plaintiffs here contend that DIM has failed to satisfy its obligations under the Act, they must show that the Act imposes upon the state obligations with which the state has failed to comply. *Id.*

1. DIM's Obligations as a Payment Agency

In count Three of the Complaint, the plaintiffs claim that where equipment or services "necessary to meet the development needs of handicapped persons are not covered by the facility's *per diem* rate, they must be provided by the SNF as a separate Medicaid benefit and the state must reimburse the SNF for any such expenditures." Complaint ¶ 33. This claim suggests that some necessary equipment and services are not covered either as separate Medicaid benefits or by the SNF's *per diem* rate. It clearly is not supported by the evidence.

To the extent that the plaintiffs claim that the *per diem* rate does not cover all of the services which must, under DIM's amended policy, be provided by the SNF, the argument fails. DIM's amended policy requires that the SNFs perform the following services: assessment of a resident's need for adaptive equipment, staff training in the efficient and safe use of the equipment, and monitoring of the resident's adjustment to the wheelchair and progress as a result of its use. *See* Findings of Fact ¶¶ 42-44. All of these services are encompassed within the general categories of "physician services," *see* 42 C.F.R. § 405.1123,[14] "nursing services," *see* 42 C.F.R. § 405.1124,[15] and "specialized rehabilitative services," *see* 42 C.F.R. § 405.1126.[16] These are services SNFs are required to provide as a condition of participation in the Medicaid program. 42 C.F.R. § 405.1121; *see O'Bannon v. Town Court Nursing Center,* 447 U.S. 773, 775-776 & n.3 (1980). The costs of all of these services are reimbursed through the facility's *per diem* rate. 42 U.S.C. § 1396a(a)(13)(A).

The plaintiffs also contend that there are services necessary to ensure the safe and adequate use of adaptive wheelchairs which are not among those that the SNFs are required to provide under DIM's amended policy.

As a preliminary matter, it must be noted that the plaintiffs have failed to identify any medically necessary service related to adaptive wheelchairs that is not mentioned specifically in the amended policy or included in the conditions of participation with which the SNFs are bound to comply. In light of the many, comprehensive requirements of the conditions of participation, *see* 42 C.F.R.§§ 405.1101-405.1137, it is difficult to imagine any medically necessary service that would not fall into one of the enumerated categories of care.

There may be many valuable, though not "medically necessary," services related to the provision of adaptive wheelchairs which the SNFs are not required by law to provide. However beneficial such services may be to the plaintiffs, the court is not authorized on that basis to order the state to provide them. It is settled that a state is not obligated under the Medicaid Act and regulations to pay, *as a separate Medicaid benefit*, for any service that is not medically necessary. *Beal v. Doe, supra*, 432 U.S. at 444-445 ("[I]t is hardly inconsistent with the objectives of the [Medicaid] Act for a state to refuse to fund *unnecessary* – though perhaps desirable – medical services.") (emphasis in original). A state may, of course, *choose* to provide funding, as a separate Medicaid benefit, for medically unnecessary services. *Id.* at 447.

The plaintiffs also contend that even if the related support services that they seek are reimbursable through the *per diem* rate, DIM should be required to pay for the services directly, or to reimburse the SNFs for the costs of the services as a separate Medicaid benefit. The basis for this claim is that the delay in receiving reimbursement for services paid through the *per diem* rate acts as a disincentive for SNFs to prescribe adaptive wheelchairs for their residents. *See* Plaintiffs' Proposed Findings ¶ 77.

There is no basis in state or federal law for this challenge to the rate reimbursement system. DIM's amended policy unquestionably comports with the state plan, which has been approved by HHS. The medical services at issue here are services that the SNFs are required to provide as a condition of participation in the Medicaid program. The written agreements between DIM and the SNFs state that the SNFs will provide services in accordance with the Medicaid law and regulations, and will receive payment for these services through a *per diem* rate. The SNFs are private facilities which voluntarily enter these agreements.

Connecticut's policy also fully comports with federal law. The use of a rate reimbursement system to pay for SNF services is, in fact, required by federal statute. The use of any other system of payment would be inconsistent with Title XIX's requirement that

> [a] state plan for medical assistance must provide for payment of . . . skilled nursing facility . . . services . . . through the use of rates . . .

42 U.S.C. § 1396a(a)(13)(A). *See also* 42 C.F.R. §§ 447.250-447.280 (procedures for setting rates for payment for SNF services). Title XIX also requires that the rates be

> reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards . . .

42 U.S.C. § 1396a(a)(13)(A). The Congress reviewed this statute as recently as 1980, when it amended the standard for reimbursement of services to encourage cost containment, *see Wisconsin Hospital Association v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984), and did not alter the system of reimbursement through the use of rates.

The plaintiffs have not suggested that the rates actually set under DIM's *per diem* rate reimbursement system (or the procedure for setting the rates) are inadequate under 42 U.S.C.

§ 1396a(a)(13)(A). Rather, the plaintiffs appear to be challenging Connecticut's decision to pay for SNF services through the use of a rate reimbursement system. Although this system indeed may generally operate to discourage SNFs from increasing costly services, *see* Findings of Fact ¶¶ 17-18, 45, the system itself clearly comports with the requirements of Title XIX. Absent a colorable constitutional basis for a challenge to the rates themselves, which is not presented here, there is no basis for this court to disturb Connecticut's policy of reimbursing SNFs, through the *per diem* rate, for skilled nursing facility services provided to recipients of adaptive wheelchairs.

The plaintiffs also seek to have this court order DIM to *provide* professional support services related to the provision of adaptive wheelchairs. Title XIX does not contemplate that state Medicaid agencies themselves may be required to provide services to recipients. Pursuant to Title XIX, states undertake to furnish "medical assistance" to eligible individuals. 42 U.S.C. § 1396a. "Medical assistance" is defined in the Medicaid Act as "*payment* of part or all of the cost of . . . care and services . . ." 42 U.S.C § 1396d (emphasis added). An individual has the right to obtain covered services from any qualified provider "who undertakes to provide him such services." 42 U.S.C. § 1396a(a)(23) (emphasis added); he has no right to demand services from an unwilling provider or to demand that the state itself provide services to him. *See Blum v. Yaretsky*, 457 U.S. 991, 1011 (1982) ("[T]he Medicaid statute requires that the States provide funding for skilled nursing services as a condition to the receipt of federal monies. . . . It does not require that the States provide the services themselves.")

In sum, the plaintiffs have failed to demonstrate that, under the Medicaid Act, DIM is obligated either to provide adaptive wheelchairs and related support services to residents of SNFs, or to pay for the related services as a separate Medicaid benefit.

2. Obligations of SNFs under the Medicaid Act

Contrary to the plaintiffs' assertions, *see* Plaintiffs' Memorandum at 18-19, an SNF is not required, as a condition

of participation in the Medicaid program, to meet the "total psychosocial needs" of its residents. Such a requirement would hold each SNF to something like a standard of perfection and would entitle SNF residents to unlimited services. Unlimited services are not available to other Medicaid-eligible persons, and any such requirement would be contrary to the Act's prohibition on the furnishing of assistance to one individual in a category (*i.e.*, the "categorically needy") that is "less in amount, duration, and scope than that furnished to others in the same category." 42 U.S.C. § 1396a(a)(10)(B)(i); *see White v. Beal*, 555 F.2d 1146, 1149 (3d Cir. 1977).

SNFs are required, as a condition of participation, *to have policies* that "reflect awareness of, and the provision for, meeting the total medical and psychosocial needs of patients." 42 C.F.R. § 405.1121(1)(1). This requirement appears in a section containing standards for the "governing body and management" of SNFs; the specific requirements for *services* to be provided to SNF residents appear at 42 C.F.R. §§ 405.1122-405.1130. *See* note 6, *infra*. Meeting the "total psychosocial needs" of residents may be a general goal to which the SNFs are expected to aspire; the achievement of that goal is not an obligation placed upon SNFs as a condition of participation in the Medicaid program. *See id.* It would be unreasonable, as well as inconsistent with the purposes of the Medicaid Act, and efforts to contain costs under that law, *see, e.g., Friedman v. Heckler*, No. 85-6046, slip op. 4775, 4783-4784 (2d Cir. June 24, 1985); *Wisconsin Hospital Association v. Reivitz, supra*, 733 F.2d at 122; *Alabama Hospital Association v. Beasley*, 702 F.2d 955, 956-958 (11th Cir. 1983), to interpret the language of certain ambiguous Medicaid regulations to require generally that states, as a condition of participation in the Medicaid program, pay for any and all services that would assist SNFs in meeting the "total psychosocial needs" of their residents.

The Medicaid regulations do require SNFs to provide, as a condition of participation, a host of enumerated services aimed at maintaining and improving the well-being of residents. Among these are "specialized rehabilitative services," including physical therapy, "as needed by patients to improve and maintain functioning," 42 C.F.R. § 495.1126. If an SNF

does not offer such services directly, it may not admit or retain patients in need of this care unless it arranges for such services to be provided by "qualified outside resources under which the facility [the SNF] assumes professional responsibilities for the services rendered." *Id.*

Uncontroverted testimony at trial established that, for many class members, adaptive wheelchairs are medically necessary to prevent serious injury. In addition, for many class members, needed physical therapy cannot be conducted because the individual has not been provided with an adaptive wheelchair.

The court has already noted that the prescription of an adaptive wheelchair, like that of any necessary item of medical care, is a service that the SNF is required to provide as a condition of participation in the Medicaid program. It is not disputed that the failure of an SNF to prescribe adaptive wheelchairs, for residents for whom such equipment is necessary, would be a breach of its obligations under the Medicaid Act and a breach of its provider agreement with DIM. An SNF's failure to prescribe an adaptive wheelchair for a resident who needs one is no less a violation of its conditions of participation than its failure to prescribe any other medically necessary service, such as drugs or surgery. Plainly, administrators of SNFs who are unwilling to undertake the professional assessment required by DIM's amended policy must (1) pay for the adaptive wheelchairs themselves and receive reimbursement through their *per diem* rate, (2) refuse to admit or retain individuals who need adaptive wheelchairs,[17] or (3) cease to be providers of services under the Medicaid program.

3. DIM's Responsibility for the Inadequacy of Care Provided to Class Members by SNFs

The plaintiffs seek to hold DIM responsible for the alleged past failures of SNFs to provide to class members adaptive wheelchairs and the necessary support services related to the provision of adaptive wheelchairs. The alleged failures by the SNFs to comply with federal law in the care of class members cannot be attributed to DIM. Despite the considerable state regulation of SNFs, it is settled that the actions of SNFs are

the actions of private parties and are not attributable to the state. *Blum v. Yaretsky, supra,* 457 U.S. at 1005-1012. Accordingly, DIM may be held accountable only for its own failures in the administration of the state's Medicaid program.

4. DIM's Obligations as an Administrative Agency

As administrator of the state's Medicaid program, DIM is required to conduct a regular program of medical review of each recipient's need for continued SNF services. 42 U.S.C. § 1396a(a)(31). The Medicaid Act calls for periodic on-site inspections, conducted by appropriately staffed "medical review teams," to assess the care being provided by SNFs to Medicaid recipients. *Id.* With respect to *each* Medicaid recipient residing in an SNF, the teams are required to assess the adequacy of the services available in the SNF "to meet his current health needs and promote his maximum well-being." *Id.*

Reports on each inspection are to contain the observations, conclusions and recommendations of the team concerning (1) "the adequacy, appropriateness and quality of all services provided in the facility or through other arrangements, including physician services to recipients," and (2) "[s]pecific findings about individual recipients in the facility." 42 C.F.R. § 456.611. In addition to sending a copy of the inspection report to DHS, *see* 42 C.F.R. § 456.612(c), DIM "must take corrective action as needed based on the report and the recommendations of the team . . ." 42 C.F.R. § 456.613.

In addition to these obligations, DIM is required to contract with DHS for DHS to establish a plan for reviewing the appropriateness and quality of care furnished to Medicaid recipients in SNFs. 42 U.S.C. § 1396a(a)(33)(A). Pursuant to the Act, DHS conducts inspections of SNFs to determine if they meet the standards for participation in the program. Certification decisions are made by DHS and forwarded to DIM. DHS must also determine, on an ongoing basis, whether participating SNFs meet the requirements for continued participation in the Medicaid program. *See* 42 U.S.C § 1396a(a)(33)(B). HHS also has authority to "look behind" the state's

determinations and to conduct independent assessments of an SNF's compliance. *Id; Estate of Smith v. Heckler*, 747 F.2d 583, 586 (10th Cir. 1984).

a. Adequacy of DIM's Program of Inspections of SNFs[18]

There is insufficient evidence in the record of this case to determine whether the frequency of DIM's inspections of SNFs or the composition of its patient review teams satisfy the requirements of 42 U.S. §§ 1396a(a)(31) and 42 C.F.R. §§ 456.600-456.614. The plaintiffs have failed to show that, with respect to these matters, DIM's inspection program falls short of the requirements imposed by the Medicaid Act and regulations. However, based on DIM's admissions alone, it is evident that the *content* of DIM's inspections falls short of the requirements imposed by federal law.

DIM acknowledges that its patient review teams do not attempt to assess the appropriateness of the plan of care ordered by a physician for an SNF resident. *See* Findings of Fact ¶ 63. DIM is thus clearly not in compliance with the requirement that its inspection reports contain "observations, conclusions and recommendations" concerning "the adequacy, appropriateness and quality of *all services* provided in the facility . . . *including physician services* . . ." 42 C.F.R. § 456.611 (emphasis added). In addition, since DIM's inspection teams do not, as a general matter, attempt to determine whether SNF residents have been evaluated for adaptive wheelchairs, *see* Findings of Fact ¶ 63, they cannot successfully determine whether the "services available in the facility" are adequate "to meet [each resident's] current health needs and promote his maximum physical well-being." 42 U.S.C § 1396a(a)(33)(B). In light of the demonstrated and undisputed need of some SNF residents for adaptive wheelchairs, an SNF that fails to perform assessments by qualified professionals of residents' needs for adaptive wheelchairs is not providing services adequate to meet the "current health needs" of its residents. *Id.*

b. Adequacy of DIM's Efforts to Remedy Deficiencies in SNFs

DIM argues that since decisions concerning certification and continued compliance are made by DHS (and by HHS,

when the federal government chooses to step in), DIM is not responsible for taking action against SNFs that fail to satisfy the conditions of participation. *See* Trial Memorandum of the Commissioner, Department of Income Maintenance (filed July 13, 1984) at 34-36, 47. DIM further argues that it is powerless to force SNFs to provide services or to comply with the conditions of participation. *Id.* at 47-48.

DIM's protestations of powerlessness are untenable for three reasons. First, the regulations specifically require DIM to take "corrective action" based on the conclusions and recommendations contained in the inspection reports. 42 C.F.R. § 456.613. While "corrective action" is not defined in the Medicaid Act or regulations, it may reasonably be assumed to include both informal requests for the SNF to correct the deficiencies, and more formal action such as cancellation or refusal to renew the SNF's provider agreement. It is unreasonable to conclude that the "corrective action" envisaged by Section 456.613 is limited to forwarding a copy of the inspection report to DHS; such a conclusion would render meaningless and redundant the requirement of Section 456.612 that a copy of *every* inspection report be forwarded to DHS. *See* 42 C.F.R. §§ 456.612(c).

Second, the provider agreements which DIM enters into with the SNFs require the SNFs to comply with their obligations under state and federal law. *See* Findings of Fact ¶ 6. Failure to do so surely would constitute "good cause" for terminating the agreement. The Medicaid regulations specifically provide that if the state Medicaid agency (the "single state agency") "has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility." 42 C.F.R. § 442.12(d).

Third, the Medicaid Act requires the state to designate a "single state agency" or "state Medicaid agency" precisely to avoid a lack of accountability. The Medicaid regulations require that in order for an agency to qualify as the "state Medicaid agency" or "single state agency," it must retain the authority to "[e]xercise administrative discretion in the administration or supervision of the plan," and to "[i]ssue policies, rules, and regulations on program matters." 42 C.F.R.

§ 431.10(e).[19] In addition, the regulations do not permit the responsibility of the state Medicaid agency to be diminished or altered by the action or inaction of other state offices or agencies. *Id.*

IV. CONCLUSION

The plaintiffs have failed to demonstrate any entitlement to relief on the basis of the first count of the Complaint; the plaintiffs proved neither that adaptive wheelchairs are prosthetic devices, nor that, should the court make such a finding, they would be entitled to any relief requested in the Complaint.

Likewise, the plaintiffs are entitled to no relief on the second and fourth counts of the Complaint; those counts allege the existence of a disparity in DIM's treatment of class members and all other Medicaid-eligible persons. The plaintiffs have failed to prove that any such disparity, even if arguably unlawful, survived DIM's 1983 amendment to its adaptive wheelchair policy.

The third count, if broadly interpreted,[20] states a claim against DIM for its failure to ensure that SNFs comply with their obligations under the Medicaid Act and regulations in regard to the provision to class members of adaptive wheelchairs and related professional support services necessary to ensure their safe and adequate use. The plaintiffs have demonstrated that certain of DIM's oversight practices – those concerning the identification and correction of deficiencies in the care provided by SNFs to class members – fail to comply with the Medicaid Act and the regulations promulgated thereunder by HHS. Corrective action is appropriate and necessary to address the inadequacy of DIM's efforts to identify and remedy deficiencies in the identification of class members requiring adaptive wheelchairs, the provision of adaptive wheelchairs to class members, and the safe and adequate use of adaptive wheelchairs by class members.

Accordingly, it is hereby ordered that counsel for all parties shall consult in an effort to reach agreement on an appropriate course of action to correct the deficiencies identified in this ruling. If such an agreement is reached, counsel

for the plaintiff shall submit, by no later than September 2, 1985, a stipulation stating the terms of such agreement, a proposed form of judgment, and a proposed order, if appropriate.

If no such agreement can be reached, each party shall file with the Office of the Clerk, by no later than September 16, 1985, a proposed form of judgment and, if appropriate, a proposed order for entry by the court. In these circumstances, each party shall also file, by no later than September 16, 1985, a memorandum of law, of not more than ten (10) pages in length, supporting entry of that party's proposed judgment and order. The proposed judgments and orders shall concern only the issues of DIM's failure to comply with its obligations, as identified in this ruling, (1) to assess, in the course of its periodic inspections, the adequacy of services provided by SNFs to class members, insofar as those services relate to the assessment of class members for adaptive wheelchairs, the provision of adaptive wheelchairs to class members, and the safe and adequate use of adaptive wheelchairs by class members; and (2) to take appropriate "corrective action," *see* 42 C.F.R. § 456.613, to remedy the deficiencies identified by its patient review teams.

It is so ordered.

Dated at New Haven, Connecticut, this 17th day of July, 1985.

/s/ José A. Cabranes
José A. Cabranes
United States District Judge

NOTES

1. United States Attorney Alan H. Nevas and Assistant United States Attorney Frank H. Santoro entered limited appearances for the sole purpose of objecting to portions of a deposition of a witness employed by the United States Department of Health and Human Services ("HHS"). *See* Limited Appearance of Counsel (filed Jan. 25, 1984). The United States Government is not a party to this case.

2. The complaint (filed Feb. 18, 1982) named defendant New Brook Hollow Health Center, Inc. as a representative of a class of skilled nursing facilities ("SNFs"). The plaintiffs moved for certification of a defendant class of SNFs "housing handicapped persons who need adaptive wheelchairs if their health and development needs are to be properly addressed." Complaint ¶ 11. The motion for certification of a defendant class was denied by oral ruling at a hearing held on October 18, 1982.

3. While the term "programming" is used repeatedly in the plaintiffs' post trial submissions, *see* Plaintiffs' Post Trial Memorandum (filed June 21, 1984) ("Plaintiffs' Memorandum"), Proposed Findings of Fact of the Individual Plaintiffs (filed June 21, 1984), Plaintiffs' Proposed Conclusions of Law (filed June 14, 1984), Plaintiffs' Memorandum Concerning Jurisdiction and Class Certification (filed July 16, 1984), it is not defined explicitly by the plaintiffs. The term, as it has been used by the plaintiffs, appears to refer to an "individually prescribed" plan of services and treatments "which are designed to promote [an individual's] maximum physical, mental, and psychosocial functioning, to prevent the further loss of social interaction, vocation, and daily living skills, and to prevent further physical harm and physical deterioration." Plaintiffs' Memorandum at 5.

4. The distinction between payment for an item provided to an SNF resident as a separate Medicaid benefit (in which DIM makes payment directly to the item's supplier) and payment for an item through the SNF's *per diem* rate (in which the SNF pays for the item and receives reimbursement indirectly through its *per diem* rate) is discussed *infra*, at Findings of Fact ¶¶ 17-20, and *infra*, at 30-35.

5. The plaintiffs' Motion to Amend Complaint (filed Oct. 15, 1984) sought to add both statutory and constitutional claims, and to expand this action to include challenges to numerous policies of the defendant that have no bearing on the provision of adaptive wheelchairs. The amended complaint would have brought into issue hundreds of alleged deficiencies in the defendant's administration of the Medicaid program. *See* proposed Amended Complaint (attachment to Motion to Amend Complaint); Ruling on Motion to Amend Complaint (filed July 12, 1985).

6. The conditions of participation set minimum standards for participating SNFs in the following categories: compliance with

federal, state and local laws, 42 C.F.R. § 405.1120; governing body and management, 42 C.F.R. § 405.1121; medical direction, 42 C.F.R. § 405.1122; physician services, 42 C.F.R. § 405.1123; nursing services, 42 C.F.R. § 405.1124; dietetic services, 42 C.F.R. § 405.1125; specialized rehabilitative services, 42 C.F.R. § 405.1126; pharmaceutical services, 42 C.F.R. § 405.1127; laboratory and radiologic services, 42 C.F.R. § 405.1128; dental services, 42 C.F.R. § 405.1129; social services, 42 C.F.R. § 405.1130; patient activities, 42 C.F.R. § 405.1131; compilation and retention of medical records, 42 C.F.R. § 405.1132; provisions for transferring residents to hospitals, 42 C.F.R. § 405.1133; physical environment, 42 C.F.R. § 405.1134; infection control 42 C.F.R. § 405.1135; disaster preparedness, 42 C.F.R. § 405.1136; and utilization review of its services, 42 C.F.R. § 405.1137.

7. An "intermediate care facility" is an institution that

> is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services . . . which can be made available to them only through institutional facilities, . . .

42 U.S.C. § 1396d(c).

8. 42 C.F.R. § 440.40 defines "skilled nursing facility services" as services that are

> (i) Needed on a daily basis and required to be provided on an inpatient basis under [42 C.F.R.] §§ 409.31-409.35 . . .
>
> (ii) Provided by . . . a facility or distinct part of a facility that is certified to meet the requirements for participation under Subpart C of Part 442 of this subchapter [42 C.F.R. §§ 442.100-442.115], as evidenced by a valid agreement between the Medicaid agency and the facility for providing skilled nursing facility services and making payments for services under the plan . . . ; and
>
> (iii) Ordered by and provided under the direction of a physician.

9. 42 C.F.R. § 440.120(c) states:

> "Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to–
>
> (1) Artificially replace a missing portion of the body;
>
> (2) Prevent or correct physical deformity or malfunction; or
>
> (3) Support a weak or deformed portion of the body.

10. The "categorically needy" include families with dependent children eligible for public assistance under the Aid to Families with Dependent Children program, 42 U.S.C. § 601, *et. seq.*, and the aged, blind, and disabled eligible for benefits under the Supplemental Security Income program, 42 U.S.C. § 1381, *et seq.* The "medically needy" include other persons who do not qualify as "categorically needy" but who do not have the financial resources to pay for necessary medical care. *See* 42 U.S.C. § 1396a(a)(10)(A), (C).

11. 42 U.S.C. § 1395x(j) defines a "skilled nursing facility" as an institution which

> (1) is primarily engaged in providing to inpatients (A) skilled nursing facility services [defined at 42 C.F.R. § 440.40, *see* note 8, *supra*] for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
>
> (2) has policies, which are developed with the advice of . . . a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;
>
> (3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;
>
> (4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and

(B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k) of this section;

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing;

(10) has in effect an overall plan and budget that meets the requirements of subsection (z) of this section;

(11) complies with the requirements of section 1320a-3 of this title;

(12) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

(13) meets such provisions of such edition . . . of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes . . . ;

(14) establishes and maintains a system that (A) assures a full and complete accounting of its patients' personal funds, and (B) includes the use of such separate account for such funds as will preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient; and

(15) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary . . . ;

except that such term shall not . . . include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. . . .

12. Following its adoption of the amended policy, DIM moved to dismiss the action on grounds of mootness and failure to join an indispensible party (HHS). *See* Motion to Dismiss Pursuant to Rules 12 and 19 (filed Nov. 14, 1984). The motion was denied by an oral ruling of December 5, 1983. DIM's claim of mootness was denied for substantially the reasons stated here. DIM's argument that the action should be dismissed for failure to join an indispensible party was denied due to DIM's failure to show that HHS could not be joined as a proper party defendant. *See* Certified Official Transcript of Hearing of December 5, 1983 (filed Dec. 8, 1983).

13. The plaintiffs apparently concede this point, because neither claim is addressed in the Plaintiffs' Memorandum.

14. 42 C.F.R. § 405.1123 states, in pertinent part:

Patients in need of skilled nursing or rehabilitative care are admitted to the facility only upon the recommendation of, and remain in the care of, a physician.

. . . The facility has a policy that the health care of every patient must be under the supervision of a physician who, based on a medical evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of total patient care. . . . The patient is seen by his attending physician at least once every 30 days for the first 90 days following admission. The patient's total program of care (including medications and treatments) is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days and revised as necessary. A progress note is written and signed by the physician at the time of each visit, and he signs all his orders. Subsequent to the 90th day following admission, an alternative schedule for physician visits may be adopted. . . . This alternate schedule does not apply for patients who require special

ized rehabilitative services .... At no time may the alternative schedule exceed 60 days between visits.

15. 42 C.F.R. § 405.1124 states, in pertinent part:

> (c) ... The facility provides 24-hour nursing services which are sufficient to meet total nursing needs and which are in accordance with the patient care policies developed as provided in [42 C.F.R.] § 405.1121 (1). The policies are designed to ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing care as needed ...
>
> (d) ... In coordination with the other patient care services to be provided, a written patient care plan for each patient is developed and maintained by the nursing service consonant with the attending physician's plan of medical care, and is implemented upon admission. ...
>
> (e) ... Nursing personnel are trained in rehabilitative nursing, and the facility has an active program of rehabilitative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self-care and independence. Rehabilitative nursing care services are performed daily for those patients who require such service, and are recorded routinely.

16. 42 C.F.R. § 405.1126 states, in pertinent part:

> In addition to rehabilitative nursing ... the skilled nursing facility provides, or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (*i.e.*, physical therapy, speech pathology and audiology, and occupational therapy) as needed by patients to improve and maintain functioning. These services are provided upon the written order of the patient's attending physician. ...
>
> (a) ... Specialized rehabilitative services are provided, in accordance with accepted professional practices, by qualified therapists or other supportive personnel under the supervision of qualified therapists. ...
>
> (b) ... A report of the patient's progress is communicated to the attending physician within 2 weeks of the

initiation of the specialized rehabilitative services. The patient's progress is thereafter reviewed regularly, and the plan of rehabilitative care is reevaluated as necessary, but at least every 30 days, by the physician and the therapist(s).

17. The court does not suggest that administrators of SNFs should be permitted to adopt policies of refusing to admit individuals requiring adaptive wheelchairs. Whether an SNF's institution of such a policy would enable DIM to cancel a provider agreement with the SNF is not an issue before the court.

18. The adequacy of DIM's patient review inspections was not an issue explicitly raised by the plaintiffs in the Complaint. However, it appears that all parties viewed this issue as one contained within count three of the Complaint. DIM's counsel did not object to the introduction at trial of evidence concerning the inspection program. Furthermore, DIM stipulated to several facts concerning this program. *See* Stipulation (filed Jan. 12, 1984). Therefore, there can be no claim of unfairness or surprise in the court's consideration of this issue. *See* note 20, *infra*. Accordingly, the court has considered the evidence in the record of this case concerning DIM's inspections of SNFs and considers this issue to be properly presented, insofar as it relates to the provision of adaptive wheelchairs and support services related to the provision of adaptive wheelchairs.

19. 42 C.F.R. § 431.10(e) states:

> In order for an agency to qualify as the Medicaid agency –
>
> (1) The agency must not delegate, to other than its own officials, authority to –
>
> (i) Exercise administrative discretion in the administration or supervision of the plan, or
>
> (ii) Issue policies, rules, and regulations on program matters.
>
> (2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

20. A flexible construction of the Complaint is, in these circumstances, consistent with the command of Rule 8(f), Fed. R. Civ. P., that "all pleadings shall be so construed as to do substantial justice." *See* 5 Wright, Miller & Kane, *Federal Practice and Procedure* § 1286, at 380-386 (rev. 2d ed. 1985) (broad construction of complaint is consistent with philosophy and intent of Federal Rules of Civil Procedure); note 17, *supra.*

APPENDIX D:

JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF CONNECTICUT, DATED OCTOBER 8, 1985

UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

DALE HILLBURN, by his parents and next friend Ralph and Eleanor Hillburn;	:: CIVIL NO. :: H 82-200 (JAC)
JAMES CORBETT, by his next friend, Robert Reid;	
SANDRA FUCHS, by her mother and next friend, Florence Fuchs; and	
STEPHEN KAPLANKA, and MARK KAPLANKA, by their mother and next friend, Dorothy Napolitano	
vs.	
COMMISSIONER, DEPARTMENT OF INCOME MAINTENANCE	:: OCTOBER 1, 1985

JUDGMENT

This action having come on for consideration before the undersigned; and,

This Court after considering five days of trial testimony, the documentary evidence, post trial submissions and argument of counsel, filed a Memorandum of Decision on July 17, 1985; and

After having further considered the proposed forms of judgment and supporting memoranda submitted by the parties, hereby ORDERS, ADJUDGES AND DECREES that:

I. Miscellaneous

(1) The plaintff class is defined as:

All Medicaid recipients residing in or admitted to Skilled Nursing Facilities in the State of Connecti-

cut on or after February 18, 1982, who, under defendant's policies and practices, cannot obtain the adaptive wheelchairs necessary to maintain their health and insure their effective development.

See Ruling on plaintiffs' Motion to Amend Class Certification (filed Sept. 19, 1984) at 3.

(2) The defendant in this action is the Commissioner of the Department of Income Maintenance, (the "defendant" or the "Commissioner") which is the single state agency for purposes of administration of Connecticut's state plan under the Title XIX Medical Assistance ("Medicaid") Program. This judgment in binding on the Commissioner in his official capacity as Commissioner of the Department of Income Maintenance and on any successors in office.

(3) An adaptive wheelchair for purposes of this decree is a wheelchair that is designed to support and properly position a disabled person's body whose disabilities preclude effective use of a standard wheelchair. It must be individually designed to fit the unique needs of a particular individual, so as to preclude its use by any other individual.

(4) For purposes of this decree, related services necessary to ensure the safe and adequate use of adaptive wheelchairs in skilled nursing facilities (or "related services") means:

a) an asessment of the patient's need for an adaptive wheelchair by a physical therapist and a physician;

b) the participation of a physical therapist or occupational therapist in the design and construction of an adaptive wheelchair;

c) training of the staff of the skilled nursing facility in the use and routine maintenance of adaptive wheelchairs;

d) periodic monitoring of the resident's use of the adaptive wheelchair by a physician, physical therapist and the nursing staff of the facility for the patient's tolerance

to the chair and for the continued appropriateness of the adaptive wheelchair;

e) a 24-hour per day "positioning plan" for each user of an adaptive wheelchair.

II. Requirements of Medical Review Teams

(1) The defendant is hereby enjoined to ensure that the Department's medical review teams, in the course of required inspections of the adequacy of care conducted pursuant to Subpart I, Part 456 of Title 42 of the Code of Federal Regulations, 42 C.F.R. § 456.600-456.614, shall inspect and determine whether or not skilled nursing facilities participating in Connecticut's Medical Assistance Program under Title XIX of the Social Security Act ("Medicaid"), 42 U.S.C. § 1396 *et seq.*, have adequately assessed class members needs for adaptive wheelchairs and whether skilled nursing facilities have arranged for the provision of adaptive wheelchairs and related services necessary to ensure the safe and adequate use of adaptive wheelchairs in skilled nursing facilities for class members who require such services.

(2) Medical review teams shall identify potential class members in the course of regularly scheduled inspections of the adequacy of care, conducted pursuant to Subpart I, Part 456 of Title 42 of the Code of Federal Regulations, 42 C.F.R. 456.600-456.614, through discussions with the staff of the skilled nursing facility, review of facility records and a physical inspection of all Title XIX-assisted, non-ambulatory patients who appear to have difficulty maintaining proper bodily alignment in a standard wheelchair. A compilation of potential classmembers shall be maintained by the Department and provided periodically to counsel of record.

(3) Medical review teams shall request that skilled nursing facilities appropriately assess the need of each potential classmember for an adaptive wheelchair.

(4) In order for an assessment to be appropriate, it must conform to the requirements of the Department of Income Maintenance, which shall include, at a minimum, a require-

ment of an interdisciplinary assessment by (a) the patient's attending physician, (b) a licensed orthopedic surgeon, and (c) a board certified orthotist, a registered physical therapist or a registered occupational therapist.

(5) A Title XIX-assisted patient residing in a participating skilled nursing facility shall be considered a class member once the facility has conducted the required interdisciplinary assessments and determined that the patient requires an adaptive wheelchair and related services necessary to ensure the safe and adequate use of adaptive wheelchairs in skilled nursing facilities.

(6) If a participating skilled nursing facility fails to conduct a required interdisciplinary assessment of a potential class member as identified by the medical review team, the Title XIX assisted SNF resident shall be considered a class member for purposes of Section III of this decree relating to the Department's obligation to take "corrective action" as needed.

(7) If a Department medical review team has any reason to question the determination or actions of a skilled nursing facility relating to the provision of adaptive wheelchairs and related services, including determinations that a Title XIX assisted patient does not require an adaptive wheelchair and determinations that related services necessary to ensure the safe and adequate use of adaptive wheelchairs in skilled nursing facilities have not been provided, the medical review team shall request the assistance of the Department's Adaptive Equipment Consultant.

(8) The Department shall retain an Adaptive Equipment Consultant who shall be a licensed physical therapist experienced in the provision of adaptive wheelchairs and related services for severely disabled adults. The Department's Adaptive Equipment Consultant shall serve as a consultant to the Department's medical review teams for purposes of inspecting the adequacy of care (42 C.F.R. § 456.600 *et seq.*) related to the provision of adaptive wheelchairs and related services necessary to ensure the safe and adequate use of adaptive wheelchairs in skilled nursing facilities.

(9) The Department's Adaptive Equipment Consultant shall review the determinations and actions of skilled nursing facilities related to the provision of adaptive wheelchairs and related services necessary to ensure the safe and adequate use of adaptive wheelchairs in skilled nursing facilities upon a request by a Department medical review team. If, after taking due account of the comments of the facility's interdisciplinary team, the Department's Adaptive Equipment Consultant determines that a skilled nursing facility has clearly failed to appropriately assess or meet a class member's need for an adaptive wheelchair or related services, the defendant is enjoined to take "corrective action" as needed to remedy the situation pursuant to the terms of Section III of this decree.

(10) The defendant is required to inspect the adequacy of care related to the provision of adaptive wheelchairs and related services necessary to ensure the safe and adequate use of adaptive wheelchairs in skilled nursing facilities (42 C.F.R. § 456.600) in any case where the class member is a Title XIX assisted patient and the class member resides in a nursing facility that is (a) certified to participate in the Medicaid Program as a skilled nursing facility and (b) has elected to participate in the Medicaid Program as a skilled nursing facility.

III. Requirement to Take Corrective Action As Needed.

(1) The defendant is hereby enjoined to ensure that the Department shall take corrective action as needed in response to the findings of the Department's medical review teams, made pursuant to Subpart I, Part 456 of Title 42, Code of Federal Regulations, 42 C.F.R. § 456.600-§ 456.614, that participating skilled nursing facilities have failed to adequately assess the need of Title XIX-assisted patients for adaptive wheelchairs, that participating skilled nursing facilities have failed to arrange for the provision of appropriate adaptive wheelchairs for Title XIX-assisted patients who require adaptive wheelchairs, or that participating skilled nursing facilities have failed to provide related services necessary to ensure the safe and adequate use of adaptive wheelchairs in skilled nursing facilities.

(2) "Corrective action as needed," as referred to in Subparagraph (1) above, includes those steps which the Commissioner, or his designees, deem to be reasonable to ensure that skilled nursing facilities provide adaptive wheelchairs and related services to class members, including, but not necessarily limited, to:

a) consultation with the medical staff of the skilled nursing facility by the Department's medical review teams, the Department's Adaptive Equipment Consultant or the Department's Medical Director;

b) filing complaints with the appropriate Medical Society requesting peer review and consultation;

c) filing complaints with the Division of Medical Quality Assurance, Department of Health Services, requesting the initiation of an investigation by said Division concerning the adequacy of medical services provided by the licensed professional staff of the facility (including physicians, physical therapists, occupational therapists, nurses and nursing home administrators) pursuant Conn. Gen. Stat. § 19a-14 *et seq.*, which includes authority to initiate licensure revocation or suspension proceedings and the imposition of civil penalties. See Conn. Gen. Stat. § 19a117.

d) filing complaints with the Division of Hospital and Medical Care of the Department of Health Services, which is the survey and certification agency in Connecticut responsible for determining the facility's compliance with the conditions of participation, 42 U.S.C. § 1396a(a)(9), 42 U.S.C. § 1396a(a)(33), for purposes of determining whether or not the facility warrants continued certification and participation in the Medical Assistance Program as a skilled nursing facility, or for the initiation of such other proceedings which said Division may deem appropriate and within the scope of its authority, including suspension or revocation of the facility's license, Conn. Gen. Stat. § 19a-494, initiation of actions seeking injunctive relief, Conn. Gen. Stat. § 19a-523, or the imposition

of citations imposing civil penalties pursuant to Conn. Gen. Stat. § 19a-524-§ 19a-529.

(3) If corrective action taken or initiated by the Department, including informal consultation and complaints filed with the Department of Health Services, fail to remedy the failure of a participating skilled nursing facility to provide an adaptive wheelchair and related services necessary to ensure the safe and adequate use of adaptive wheelchairs in skilled nursing facilities to one or more individual Title XIX-assisted patients in the facility, the defendant Commissioner, Department of Income Maintenance, shall terminate the facility's provider agreement with the Department of Income Maintenance. In such circumstances, the Commissioner shall terminate the facility's provider agreement notwithstanding the fact that the facility is otherwise certified to participate in the Title XIX Medical Assistance Program by the Connecticut Department of Health Services or the United States Department of Health and Human Services pursuant to the provision of 42 U.S.C. § 1396a(a)(9), 42 U.S.C. § 1396a(a)(33), 42 U.S.C. § 1396a(i), 42 U.S.C. § 1396i, 42 C.F.R. § 440.40 and 42 C.F.R. § 442.1-442.202, and there is no other basis in federal law (such as violation of civil right requirements) for a termination of the provider agreement. Any such termination of a provider agreement shall comply with the procedural requirements of federal law, including the requirements of notice and an opportunity for an administrative hearing by the facility. See 42 C.F.R. § 431.151-§ 431.154.

IV. Quarterly Reports

The defendant shall submit quarterly reports to the Court on the implementation of the terms of this decree. Copies of the quarterly reports shall be submitted to counsel of record who may submit any comments within ten (10) days of the filing of a quarterly report. One year after the entry of this decree the Court will determine whether or not the continued submission of Quarterly Reports is warranted or if any other remedial relief is appropriate.

BY ORDER OF THE COURT,

/s/ José A. Cabranes
José A. Cabranes
United States District Judge

Dated at New Haven, Connecticut, this 8th day of October, 1985.

APPENDIX E:

STATUTES AND REGULATIONS

STATUTES – Title 42, United States Code

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must–

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(9) provide–

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(23) except as provided in section 1396n and except in the case of Puerto Rico, the Virgin Islands, and Guam, provide

that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services;

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this subchapter;

(31) with respect to skilled nursing facility services (and with respect to intermediate care facility services, where the State plan includes medical assistance for such services) provide–

(A) with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(B) with respect to each skilled nursing or intermediate care facility within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;

(33) provide–

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

§ 1396i. Certification and approval

(a) Skilled nursing facilities

(1) Whenever the Secretary certifies an institution in a State to be qualified as a skilled nursing facility under sub-

chapter XVIII of this chapter, such institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1396a(a)(28) of this title.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any institution which has applied for certification by him as a qualified skilled nursing facility.

REGULATIONS – Title 42, Code of Federal Regulations

§ 431.10 Single State agency. . . .

(e) *Authority of the single State agency.* In order for an agency to qualify as the Medicaid agency –

(1) The agency must not delegate, to other than its own officials, authority to –

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

§ 431.151 Scope and applicability.

This subpart specifies the appeal procedures the State must make available to a skilled nursing facility (SNF) or

intermediate care facility (ICF) for which the State denies, terminates, or fails to renew certification or a provider agreement for the Medicaid program.

§ 440.40 Skilled nursing facility services for individuals age 21 or older (other than services in an institution for tuberculosis or mental diseases). EPSDT, and family planning services and supplies.

(a) *Skilled nursing facility services.*

(1) "Skilled nursing facility for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases," means services that are–

(i) Needed on a daily basis and required to be provided on an inpatient basis under §§ 409.31-409.35 of this chapter.

(ii) Provided by (A) a facility or distinct part of a facility that is certified to meet the requirements for participation under Subpart C of Part 442 of this subchapter, as evidenced by a valid agreement be between the Medicaid agency and the facility for providing skilled nursing facility services and making payments for services under the plan; or (B) if specified in the State plan, a swing-bed hospital that has an approval from HCFA to furnish skilled nursing facility services in the Medicare program; and

(iii) Ordered by and provided under the direction of a physician.

(2) Skilled nursing facility services includes services provided by any facility located on an Indian reservation and certified by the Secretary as meeting the requirements of Subpart K of Part 405 of this chapter.

§ 442.12 Provider agreement: General requirements.

(a) *Certification and recertification.* Except as provided in paragraph (b) of this section, a Medicaid agency may not

execute a provider agreement with a facility for SNF or ICF services nor make Medicaid payments to a facility for those services unless the Secretary or the State survey agency has certified the facility under this part to provide those services. (See § 442.101 for certification by the Secretary or by the State survey agency).

(b) *Exception.* The certification requirement of paragraph (a) of this section does not apply with respect to Christian Science sanitoria operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass.

(c) *Conformance with certification condition.* An agreement must be in accordance with the certification provisions set by the Secretary or the survey agency under Subpart C of this part.

(d) *Denial for good cause.* (1) If the Medicaid agency has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility.

(2) A provider agreement is not a valid agreement for purposes of this part even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

§ 442.105 Certification with deficiencies: General provisions.

If a survey agency finds a facility deficient in meeting the standards specified under Subpart D, E, F, or G of this part, the agency may certify the facility for Medicaid purposes under the following conditions:

(a) The agency finds that the facility's deficiencies, individually or in combination, do not jeopardize the patient's health and safety, nor seriously limit the facility's capacity to give adequate care. The agency must maintain a written justification of these findings.

(b) The agency finds acceptable the facility's written plan for correcting the deficiencies.

Subpart I – Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases

§ 456.600 Purpose.

This subpart prescribes requirements for periodic inspections of care and services in skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and institutions for mental diseases (IMD's).

§ 456.601 Definitions.

For purposes of this subpart –

"Facility means a skilled nursing facility, an institution for mental diseases, or an intermediate care facility.

"Intermediate care facility" includes institutions for the mentally retarded or persons with related conditions but excludes Christian Science sanatoria operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass.

"Institution for mental diseases" includes a mental hospital, a psychiatric facility, and a skilled nursing or intermediate care facility that primarily cares for mental patients.

"Psychiatric facility" includes a facility or program that provides inpatient psychiatric services for individuals under 21, as specified in § 441.151 of this chapter, but does not include psychiatric wards in acute care hospitals.

§ 456.602 Inspection team.

(a) A team, as described in this section and § 456.603 must periodically inspect the care and services provided to recipients in each facility.

(b) Each team conducting periodic inspections must have a least one member who is at physician or registered nurse and other appropriate health and social service personnel.

(c) For an IMD other than an ICF, each team must have a psychiatrist or physician knowledgeable about mental institutions and other appropriate mental health and social service personnel.

(d) For an ICF that primarily cares for mental patients, each team must have at least one member who knows the problems and needs of mentally retarded individuals.

(e) For an institution for the mentally retarded or persons with related conditions, each team must have at least one member who knows the problems and needs of mentally retarded individuals.

(f) For ICF's primarily serving individuals 65 years of age or older, each team must have at least one member who knows the problems and needs of those individuals.

(g) If there is no physician on the team, the Medicaid agency must insure that a physician is available to provide consultation to the team.

(h) If a team has one or more physicians, it must be supervised by a physician.

§ 456.603 Financial interests and employment of team members.

(a) Except as provided in paragraph (b) of this section –

(1) No member of a team that reviews care in a SNF may have a financial interest in or be employed by any SNF; and

(2) No member of a team that reviews care in an ICF may have a financial interest in or be employed by any ICF.

(b) A member of a team that reviews care in an IMD or an institution for the mentally retarded or persons with related conditions –

(1) May not have a financial interest in any institution of that same type but may have a financial interest in other facilities or institutions; and

(2) May not review care in an institution where he is employed but may review care in any other facility or institution.

§ 456.604 Physician team member inspecting care of recipients.

No physician member of a team may inspect the care of a recipient for whom he is the attending physician.

§ 456.605 Number and location of teams.

There must be a sufficient number of teams so located within the State that onsite inspections can be made at appropriate intervals in each facility caring for recipients.

§ 456.606 Frequency of inspections.

The team and the agency must determine, based on the quality of care and services being provided in a facility and the condition of recipients in the facility, at what intervals inspections will be made. However, the team must inspect the care and services provided to each recipient in the facility at least annually.

§ 456.607 Notification before inspection.

No facility may be notified of the time of inspection more than 48 hours before the scheduled arrival of the team.

§ 456.608 Personal contact with and observation of recipients and review of records.

(a) For recipients under age 21 in psychiatric facilities and recipients in SNFs and ICFs, other than those described in paragraph (b) of this section, the team's inspection must include–

(1) Personal contact with and observation of each recipient; and

(2) Review of each recipient's medical record.

(b) For recipients age 65 or older in IMDs, the team's inspection must include–

(1) Review of each recipient's medical record; and

(2) If the record does not contain complete reports of periodic assessments required by § 441.102 of this subchapter or, if such reports are inadequate, personal contact with and observation of each recipient

[43 FR 45266, Sept. 29, 1978, as amended at 44 FR 17940, Mar. 23, 1979]

§ 456.609 Determinations by team.

The team must determine in its inspection whether–

(a) The services available in the facilitiy are adequate to–

(1) Meet the health needs of each recipient, and the rehabilitative and social needs of each recipient in an ICF: and

(2) Promote his maximum physical, mental, and psychosocial functioning.

(b) It is necessary and desirable for the recipient to remain in the facility;

(c) It is feasible to meet the recipient's health needs and, in an ICF, the recipient's rehabilitative needs, through alternative institutional or noninstitutional services; and

(d) Each recipient under age 21 in a psychiatric facility and each recipient in an institution for the mentally retarded or persons with related conditions is receiving active treatment as defined in § 441.154 of this subchapter.

§ 456.610 Basis for determinations.

In making the determinations on adequacy of services and related matters under § 456.609 for each recipient, the team may consider such items as whether –

(a) The medical evaluation, any required social and psychological evaluations, and the plan of care are complete and current; the plan of care and, where required, the plan of rehabilitation are followed; and all ordered services, including dietary orders, are provided and properly recorded;

(b) The attending physician reviews prescribed medications –

(1) At least every 30 days in SNFs, psychiatric facilities, and mental hospitals; and

(2) At least quarterly in ICFs;

(c) Tests or observations of each recipient indicated by his medication regimen are made at appropriate times and properly recorded;

(d) Physician, nurse, and other professional progress notes are made as required and appear to be consistent with the observed condition of the recipient;

(e) The recipient receives adequate services, based on such observations as –

(1) Cleanliness;

(2) Absence of bedsores;

(3) Absence of signs of malnutrition or dehydration; and

(4) Apparent maintenance of maximum physical, mental, and psychosocial function;

(f) In an ICF, the recipient receives adequate rehabilitative services, as evidenced by –

(1) A planned program of activities to prevent regression; and

(2) Progress toward meeting objectives of the plan of care;

(g) The recipient needs any service that is not furnished by the facility or through arrangements with others; and

(h) The recipient needs continued placement in the facility or there is an appropriate plan to transfer the recipient to an alternate method of care.

§ 456.611 Reports on inspections.

(a) The team must submit a report promptly to the agency on each inspection.

(b) The report must contain the observations, conclusions, and recommendations of the team concerning–

(1) The adequacy, appropriateness, and quality of all services provided in the facility or through other arrangements, *including physician services* to recipients; and

(2) Specific findings about individual recipients in the facility.

(c) The report must include the dates of the inspection and the names and qualifications of the members of the team.

§ 456.612 Copies of reports.

The agency must send a copy of each inspection report to–

(a) The facility inspected;

(b) The facility's utilization review committee;

(c) The agency responsible for licensing, certification, or approval of the facility for purposes of Medicare and Medicaid; and

(d) Other State agencies that use the information in the reports to perform their official function, including, if inspection reports concern IMD's, the appropriate State mental health authorities.

§ 456.613 Action on reports.

The agency must take corrective action as needed based on the report and recommendations of the team submitted under this subpart.

§ 456.614 Inspections by utilization review committee.

A utilization review committee under Subparts C through F of this part may conduct the periodic inspections required by this subpart if–

(a) The committee is not based in the facility being reviewed; and

(b) The composition of the committee meets the requirements of this subpart.

§ 489.12 Decision to deny an agreement.

(a) *Bases for denial.* HCFA may refuse to enter into or renew an agreement for any of the following reasons:

(1) Principals of the provider have been convicted of fraud (see § 420.204 of this chapter);

(2) The provider has failed to disclose ownership and control interests in accordance with § 420.206 of this chapter; or

(3) The provider has been adjudged bankrupt or insolvent.

(b) *Effect of bankruptcy or insolvency.* (1)HCFA will not enter into an agreement with a provider that has been adjudged insolvent or bankrupt under appropriate State or Federal law, or against which there is pending a court pro-

ceeding to make a judgment concerning this matter. The reason for denial is that the provider is unable to give satisfactory assurances of compliance with the requirements of title XVIII of the Act.

(2) If a provider who is participating and receiving payments under Medicare is subsequently adjudged insolvent or bankrupt by a court of competent jurisdiction, HCFA will not terminate its participation in the program because of that financial condition. However, the intermediary will adjust payments to the provider (as specified in § 405.454(k) of this chapter) to preclude overpayments.

(c) *Compliance with civil rights requirements.* HCFA will not enter into a provider agreement if the provider fails to comply with civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

APPENDIX F:

EXCERPT, HEW, MEDICAL ASSISTANCE MANUAL,25-60-20, TRANSMITTED BY MSA-PRG-25 (11/13/72)

Part 5. Services and Payment in Medical Assistance Programs

5-60-00 Medical Review in Skilled Nursing Homes and Mental Hospitals

5-60-10 Legal Background and Authority

A. Section 1902(a)(26) of the Social Security Act.

B. 45 CFR 250.23

C. SRS PR 40-21, February 17, 1971.

5-60-20 Implementation

Introduction

This guideline document interprets and discusses the provisions of 45 CFR 205.23: "Periodic Medical Review and Medical Inspections in Skilled Nursing Homes and Mental Hospitals" which became effective May 3, 1971. It describes approaches that might be taken by single State agencies toward implementation of this regulation. It examines features of some medical review methods that have proven effective in a few jurisdictions; presents ideas and suggestions for the structuring and conduct of medical review programs; discusses the intent and implications of various components of the medical review process; and presents a number of aids that may be found of practical value in initiating or improving medical review activities called for under the regulation.

The medical review program called for by the regulation has two distinct parts which involve separate administrative processes. The first is a requirement for a medical evaluation of a patient's need for skilled nursing home care or for care in a mental hospital prior to admission. In the event that the individual already is an inpatient in the facility at the time application is made for title XIX benefits, the medical evaluation of need for care is called for prior to authorization of benefits. This medical evaluation ordinarily would be performed by the patient's attending physician.

The second part of the medical review program consists of a program of periodic inspections of the care of medical assistance patients who are inpatients in skilled nursing homes and mental hospitals.

Stated simply, the purpose and function of periodic medical review is to ascertain and document whether medical assistance patients in title XIX skilled nursing homes and mental hospitals are, in fact, receiving physician, skilled nursing, personal, and social services for which they are eligible that are optimum in quality, adequate in quantity, and sufficient in scope; and are being provided in a timely manner under circumstances most favorable to the promotion of the physical, emotional, social, and functional well-being of such patients.

The primary goal of periodic medical review is to ensure the provision of a range and quality of medical and nursing management, and social work support, for title XIX skilled nursing home and mental hospital patients that is necessary and commensurate with their clinical and physical needs, the optimum social functioning. In that context, the three entities most affecting the well-being of an individual medical assistance patient are his physician, the provider institution and the case worker who serves him. Appraisal of how well each of these is responding, separately and in relation to each other, in providing quality care that is timely and conforms to accepted professional standards and practices is the key aim of the patient-centered evaluations required by section 250.23. A secondary role of periodic medical review entails matching the kinds of services actually needed by medical assistance patients with facilities most capable and best suited to render such care. The approach to such determinations should be as an aspect of proper medical management of a patient's care.

In these guidelines, chapter III deals with the pre-admission phase of medical review and provides some general guides for the evaluation of need for skilled nursing home or mental hospital care. Chapters IV, V and VI deal with the second

aspect of medical review: periodic on-site inspections of care by medical review teams.

The general guides to evaluation of need for care may also be useful to medical review teams in considering the possibility of alternative care arrangements being more appropriate in individual cases. However, they should be used in this context with caution and conservatism. Special consideration must be given in these cases to the possible effects of any changes in care arrangements on the health and functional status of the patients.

5-60-20 Chapter II – Section-by-Section Interpretation of 45 CFR 250.23 (continued)

(iii) Reports and recommendations are followed by appropriate action on the part of the single State agency.

Single State agencies should follow through promptly and consistently to monitor each facility's response to and compliance with recommendations made by medical review and inspection teams for change and improvement in respect to any aspect of care being provided medical assistance patients individually or collectively. Ordinarily this would be done through the agency of the State responsible, under arrangements with the title XIX agency, for facility survey and consultation functions.

If inadequacies in the attention to a patient by an attending physician are found and reported to the single State agency, the medical director of the single State agency should contact the attending physician and advise him of the reported deficiencies. An example might be a physician failing to visit a medical assistance patient in a skilled nursing home for an extended period. The patient's medical record does not contain justification for the infrequency of visits and shows only perfunctory notes by the physician. Upon receiving such information, the medical director of the single State agency would promptly notify the responsible physician of the reviewing

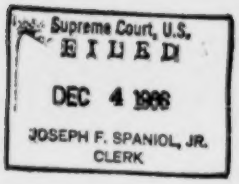
physician's findings. If no favorable response is obtained, the medical director might properly report the situation to the local medical society.

If a patient is found by the review team to need services not available at the present facility, the single State agency should make arrangements for the provision of these services or transfer to a facility capable of providing them within a reasonable period of time. A "reason-

able period" would depend upon the mental and physical conditions of the patient and the availability of alternate care.

Another example which should prompt action from the single State agency might be an elderly medical assistance patient who is unusually concerned about her immediate family or a close friend outside the facility. She has not been seen or visited in several months. The case worker supervisor of the local assistance agency should be contacted by the single State agency with a recommendation to investigate the case.

In the case of reports of reviews in mental hospitals, the coordinator of the mental health program within the single State agency should consult with the coordinator in the State mental health program and with the hospital superintendent and treatment staff regarding any reported deficiencies and recommendations from the medical review report. Together, a plan for correction of the deficiencies should be developed, and a reasonable time should be allowed for corrections to be made.



(5)

NO. 86-747

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1986

STEPHEN B. HEINTZ
Commissioner Department of
Income Maintenance
State of Connecticut

Petitioner

v.

DALE HILLBURN,
by his parents and next
friends Ralph and Eleanor Hillburn;

JAMES CORBETT,
by his next friend,
Roberta Reid;

SANDRA FUCHS
by her next friend,
Florence Fuchs

STEPHEN KAPLANKA and MARK KAPLANKA
by their mother and next friend,
Dorothy Napolitano

Respondents

ON PETITION
FOR A WRIT OF CERTIORARI

DAVID C. SHAW
Trowbridge, Ide & Greenwald, P.C.
216 Main Street
Hartford, CT 06106

SHELLEY WHITE
Connecticut Civil Liberties Union
32 Grand Street
Hartford, CT 06106

Counsel for Respondents

48pp

NO. 86-747

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STEPHEN B. HEINTZ,

Petitioner

v.

DALE HILLBURN,
by his parents and next friends,
Ralph and Eleanor Hillburn, et al.

Respondents

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

OPINIONS BELOW

The judgment of the Court of Appeals has been reported at 795 F.2d 252.

The opinion of the district court is not reported. The opinion and judgment are reproduced in the appendix to the petition for a Writ of Certiorari at 36A and 77A respectively.

QUESTIONS PRESENTED

1. Whether the State Medicaid Agency is required by federal law to determine through professional medical reviews if nursing homes are providing adaptive wheelchairs to their severely handicapped residents receiving Medicaid where appropriate.

2. Whether the state Medicaid Agency is required by federal law to take effective corrective action whenever a Medicaid recipients' need for an adaptive wheelchair has not been addressed by the nursing home in which he resides.

3. Whether the Commissioner waived his defense that the federal regulations codified at 42 C.F.R. Part 456, Subpart I are unenforceable by Medicaid recipients by not raising it until after trial.

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TABLE OF AUTHORITIES

Cases Cited:

Federal Statutes:

SUMMARY OF ARGUMENT

Certiorari should be denied because the opinion of the Court of Appeals faithfully follows the legislative and regulatory scheme established by Congress and the United States Department of Health and Human Services that is designed to guarantee that the care and services mandated by Title XIX for nursing home residents are actually delivered. Further, compliance with the lower court's opinion will not interfere with administrative enforcement of the Medicaid requirements since the court mandates only that the state implement regulatory requirements now nearly two decades old.

In amendments to Title XIX in 1968, Congress established three separate, though complementary enforcement mechanisms: (1) state surveys of facilities by state health agencies to ensure that nursing homes meet the conditions of participation; (2) inspection of care reviews to assure that services actually delivered in certified facilities promote their residents' optional functioning; and (3) utilization control. The first mechanism is essentially structural and facility oriented; the other two are patient-oriented and focus on outcomes. This case involves Connecticut's failure to implement the second enforcement mechanism designed explicitly to assure that a skilled nursing facility meets its residents' needs.

The court below was correct in requiring the defendant Commissioner to implement the patient-by-patient inspection of care reviews in accordance with the requirements of the federal statute and regulations. These requirements are clear and unambigous and Connecticut's failure to faithfully implement them has fostered and encouraged inadequate nursing home care for severely handicapped Medicaid recipients.

The court below was also correct that the state agency in charge of Medicaid must follow the federal regulatory requirement to take appropriate corrective action, including termination of a facility's provider contract as a last resort, if the intransigence of certain nursing homes continues. Strong remedial measures are necessary because classmembers have been subjected to severe health risks and even death for over a decade as a result of nursing homes refusal to provide adaptive wheelchairs to persons needing them. As Commissioner of the "single state agency" responsible for implementation of Medicaid in Connecticut, the defendant should have taken strong action before now to address this problem. Individual patient transfers, sanctions against individual nursing home physicians, and individual enforcement actions in state court are a few of

the available but never used enforcement tools which should make termination of provider contracts unnecessary. If, however, a certain nursing home ignores the need of a severely handicapped person for an adaptive wheelchair, termination of the provider contract should be available as a last resort.

The remedial orders approved by the court below are narrowly drawn to eliminate the violations of the legal rights established at trial and do not merit review by this Court. The state is directed to determine only if nursing homes are responding to individual needs for an adaptive wheelchair and to take corrective action when they are not. The Commissioner is not enjoined to take similar actions to enforce classmembers rights to other services under Medicaid such as physical therapy or theraputic feeding. The decision below requires far less of the state Medicaid Agency than the federal regulations themselves and therefore does not mandates impermissibly broad relief.

I. STATEMENT OF THE CASE

This case was filed to obtain adaptive wheelchairs and related services for three hundred of Connecticut's most severely handicapped citizens.[1] Many classmembers are senior citizens, others are retarded, but all reside in skilled nursing facilities (SNFs) and have physical handicaps of such severity that an adaptive wheelchair is necessary to enable them to properly position and align their bodies. Proper body alignment for such persons is necessary to promote safe and proper breathing, swollowing and digestion. Without an adaptive wheelchair such severely handicapped persons are at risk of suffering a deterioration in health and skin breakdown or being subjected to severe injury or death.[2] Hillburn v. Commissioner, Connecticut

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[1] The class was certified on September 19, 1983 to include: All Medicaid recipients residing in or admitted to skilled nursing facilities in the State of Connecticut on or after February 18, 1982, who, under defendant's policies and practices cannot obtain the adaptive wheelchairs necessary to maintain their health and insure their effective development.

[2] The trial record establishes that the classmembers are exposed to the following risks every day: recurring aspiration pneumonia and hospitalization because classmembers are fed in a supine position; and regurgitation and choking during feeding, reduced range of motion of limbs and progression of physical deformities and regression because of the lack of an adaptive wheelchair, twenty-four hour positioning plan, and physical therapy.

Connecticut Department of Income Maintenance, No. H82-200, slip op. at 11, 14, 15 (D. Conn. July 17, 1985); 47A, 48A.[3]

The named plaintiffs and many members of the plaintiff class were transferred from large state institutions into skilled nursing facilities (SNFs)[4] by the Connecticut Department of Mental Retardation (DMR) in the mid-seventies in order to facilitate the renovation of these facilities to federal Title XIX standards. Hillburn, slip op. at 12; 46A. Under Connecticut law, DMR retains responsibility for the classmembers it has placed and can transfer them to other facilities, but has no authority over nursing homes. Connecticut General Statutes section 19a-451(1). This lawsuit became necessary because DMR and state officials from two other state agencies, each responsible for implementation of some or all of Connecticut's Medicaid plan, ignored obvious needs of the most severely handicapped of Connecticut's nursing home residents for more than a decade.[5]

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[3] References to the appendix to the Petition for a Writ of Certiorari in this case will be made by giving a page reference followed by the letter A.

[4] The term "skilled nursing facility" is defined at 42 U.S.C. section 1395x(j).

[5] The petitioner's assertion that adaptive wheelchairs have been available only in "recent years", petition p. 4, is untrue. The (f.n. cont)

Connecticut participates in the federal-state Medicaid program authorized by Title XIX of the Social Security Act, 42 U.S.C. section 1396-1397f. In accordance with federal Medicaid requirements, see 42 C.F.R. section 431.1 and 431.10, Connecticut has named DIM as the "single state agency" responsible for administering the state Medicaid program. Hillburn, slip op. at 9; 43A. DIM, in turn, has submitted the state's Medicaid plan to the Department of Health and Human Services (HHS). This plan has been approved by HHS. In the plan, DIM, as the state Medicaid agency, promises to carry out the requirements of federal law in exchange for federal reimbursement of fifty percent of all qualifying services delivered under the program. In its capacity as the state Medicaid agency, DIM has entered into written contracts called "provider agreements" with each SNF that participates in the Medicaid program. These contracts are renewed yearly. The provider agreements state that the SNF will provide care and services in conformity with Title XIX, and will meet the conditions of partcipation detailed in HHS regulations

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(f.n. cont.)
district court found that adaptive wheelchairs have been commercially available since 1980. 48A. However, the trial record and the orders of other district courts, See Halderman v. Pennhurst, 446 F. Supp 1295, 1329 (1977), establish that wheelchairs have been individually adapted by qualified therapists for well over a decade.

conditions of participation detailed in HHS regulations. Hillburn, slip op. at 8, 9, 10; 43A, 44A.

In addition to paying for covered medical services to eligible individuals by participating providers, DIM has administrative responsibilities as the state Medicaid agency. These responsibilities include entering into an agreement with Connecticut's State Health Agency, the Connecticut Department of Health Services (DHS), to perform periodic survey and certification inspections of SNFs to determine if they satisfy the conditions of participation in the program prescribed by HHS [42 U.S.C. section 1396 a(a)(33)(A); 42 C.F.R. sections 405.1121 - 405.1137]; to make periodic inspections of SNFs to determine if each Medicaid recipient is receiving appropriate care [42 U.S.C. section 1396 a(a)(31)(B); 42 C.F.R. section 456.609, 456.610, 456.611,]; to take corrective action against noncompliant SNFs [42 C.F.R. section 456.613]; and to issue policy and otherwise supervise the implementation of the state plan in a manner consistent with the objectives of Title XIX. 42 U.S.C. section 1396a(a)(17); 42 C.F.R. section 431.10(e). Hillburn, slip op. at 21-23; 64A, 65A, 66A.

The state stipulated, and the district court found that DIM implements the Medicaid program such that no state agency

determines whether necessary care and services, even medical necessities like adaptive wheelchairs, are actually delivered to classmembers. The state health agency (DHS) determines in the course of its licensing and certification inspections whether each facility has the capacity to deliver adequate care but does not determine whether individual SNF patients are actually receiving necessary medical care or rehabilitative services. Further, DHS takes no action if it is determined in the course of these inspections that a single resident or group of residents are not receiving services mandated by Medicaid. Hillburn, slip op. at 22; 53A.[6] The only other state agency with authority over nursing homes is the defendant DIM. The petitioner stipulated and the district court found, however, that DIM, like DHS, does not look at the services each classmember actually receives during patient reviews. Rather, it looks only at whether the physician orders are being executed. Even if a deficiency is identified in the course of these inspections, DIM takes no

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[6] The district court in Connecticut has agreed with DHS that it is serving its proper role under Medicaid. On March 4, 1982 then Chief United States District Judge T. Emmet Clarie ruled, in a case involving similar issues, C.A.R.C. v. Thorne, No. H78-653 (D. Conn., Consent Decree accepted April 9, 1984), that DHS had "no statutory authority" over the quality of care actually delivered to individual nursing home residents.

action to correct the deficiencies. Hillburn, slip op. at 23; 53A.

The district court judge held that the DIM inspections do not comply with the federal regulations. In particular, he held that the DIM inspections do not determine whether the "services available at the facility" are adequate "to meet [each resident's] current health needs and promote his maximum physical well-being" in apparent violation of 42 U.S.C. section 1396 a(a)(31)(B) and that the reports prepared during these inspections do not contain "observations, conditions and recommendations" concerning "the adequacy, appropriateness and quality of all services provided in the facility... including physician services ..." in violation of 42 C.F.R. section 456.611. He also held that DIM's failure to take effective corrective action based on the patient review team's reports violates 42 C.F.R. section 456.613. Hillburn, slip op. at 41 - 43; 65A, 66A.

On October 8, 1985, the district court entered a judgment ordering DIM to have its patient review teams, in the course of their required inspections, identify persons potentially in need of an adaptive wheelchair and request that the particular SNF involved make, on a case-by-case basis, a professional determination as to whether an adaptive wheelchair should be

provided. The court further enjoined DIM to take corrective action it deems reasonable to ensure that SNFs provide necessary adaptive wheelchairs and "related services".[7] In the event DIM's best efforts fail to remedy a SNF's failure to provide an adaptive wheelchair and related services to classmembers, DIM is enjoined to terminate the SNF's provider agreement with DIM.

The plaintiffs appealed claiming that, having found the defendant DIM in violation of the federal regulations, the district court should have ordered the full implementation of the medical review requirements of the federal law, especially in light of the very great harm the trial record shows classmembers are exposed to from misuse of behavior modifying medications, mechanical restraint, and improper feeding practices. The defendant DIM cross-appealed, arguing that DIM's medical reviews are conducted properly and that the Court orders requiring termination of provider agreements in certain circumstances were improper.

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[7] The term "related services" is narrowly defined on pages 3 and 4 of the Court's judgment to include assessment for an adaptive wheelchair, professional involvement in the design and use of the adaptive wheelchair by the facility staff and a twenty-four hour per day positioning plan. It does not require, for example, that SNFs address classmembers' needs for physical therapy or programs to reduce the inappropriate use of restraint or psychotropic medication. 83A.

The Second Circuit Court of Appeals rejected plaintiffs' appeal for broader relief and agreed with the district court that DIM is not providing the supervision of SNF health care required by federal law. Hillburn v. Maher, 795 F.2d 252 (2nd Cir. 1986). It not only agreed with the district court that the DIM inspection reports failed to comply with 42 C.F.R. 456.611, 795 F.2d at 259, but also that its inspections were in apparent violation of 42 C.F.R. 456.609 entitled "Determinations by Team" and 42 C.F.R. 456.610 entitled "Basis for Determinations". 795 F.2d at 260. Finally, the court upheld the district court's order requiring termination of the provider contracts of irremediably noncompliant facilities as being consistent with the federal regulations, especially 42 C.F.R. section 442.12(d) and the federal regulatory scheme that empowers the single state agency to implement the Medicaid program in a manner consistent with the objectives of Medicaid. 795 F.2d at 261.

II. THE COURT OF APPEALS' HOLDING THAT THE STATE MEDICAID AGENCY MUST DETERMINE THROUGH PROFESSIONAL MEDICAL REVIEWS WHETHER NURSING HOMES ARE PROVIDING ADAPTIVE WHEELCHAIRS TO THEIR SEVERELY HANDICAPPED RESIDENTS RECEIVING MEDICAID WHERE APPROPRIATE IS PLAINLY CONSISTENT WITH THE FEDERAL REGULATORY SCHEME.

The defendant's argument that the federal regulations do not require DIM's patient review teams to evaluate the care each classmember receives is plainly inconsistent with the federal scheme, and does not merit review by this Court. The district

court found that DIM's patient review teams do not assess the appropriateness of the plan of care ordered by a physician. The court below held that such inaction violates the letter and spirit of the federal regulations: 42 C.F.R. 456.609, 42 C.F.R. 456.610 and 42 C.F.R. 456.611.

The statutory basis for the independent professional review requirement is 42 U.S.C. section 1396 a(a)(31). This requirement was enacted as a result of findings by the Senate Subcommittee on Aging, following hearings conducted in 1965, that great variations existed in state nursing home standards, that there was great disparity in the manner and vigor of state enforcement efforts and that nursing home care was, as a general rule, deplorable. Accordingly, Senator Moss proposed new standards as part of the Social Security Amendments of 1967.[8] These new standards require agreements between state health agencies, which license and certify nursing homes and state welfare agencies to facilitate cooperation and communication. The requirement at issue here, medical review, was also introduced through this same legislation. The medical review requirement mandated states to perform a patient-by-patient evaluation of the adequacy of care and services provided and of the necessity for continued

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[8] Public Law 90-248, sections 224 and 234.

placement in the SNF. The Senate Report describes the importance the national legislature attached to independent patient-by-patient reviews:

> The amendment provides, furthermore, for the states to have in operation a professional medical review program under which periodic evaluations of the care provided for Title XIX patients in nursing homes... is made. Such regular independent reviews made by or on behalf of the state agency will provide a mechanism for assuring that patients are receiving appropriate care in an appropriate setting. To the extent possible, it is intended to develop active care designed to enhance the capacity of patients to care for themselves - frequently in a lower cost facility or setting. S. Rep. No. 744; 1967 U.S. Code Cong. and Adm. News 3028, 3029.

State and federal efforts to implement these requirements have been inadequate. In 1970, state inspections of nursing homes were said to demonstrate a "nonchalant indifference" to inadequate care.[9] Statements about the critical importance of independent professional review and the failure of the states to properly conduct these inspections have been voiced repeatedly since 1971 in the national legislature.[10]

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[9] 116 Cong. Rec. H27038 (August 3, 1970)

[10] See Subcomm. On Long Term Care of the Senate Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy, Introductory Report, S. Rep. No 93-1420, 93rd Cong., 2d Session (1974); U.S. Senate Subcomm. on (f.n. cont.)

The federal regulations require DIM to assemble inspection teams composed of appropriate health and social service personnel, 42 C.F.R. 456.602 (b), in sufficient numbers to conduct onsite inspections at intervals determined to be appropriate based on the quality of care being provided and the condition of the recipients. 42 C.F.R. 456.605; 42 C.F.R. 456.606. The teams are required to determine whether the care and services each classmember receives in a SNF are adequate to meet his or her needs based on personal contact with and observation of each recipient and a review of his/her medical record. 42 C.F.R. section 456.608; 42 C.F.R. section 456.609; 42 C.F.R. section 456.610; 42 C.F.R. 456.602. The teams are also required to submit a report to the single state agency (DIM) containing the observations, conclusions and recommendations of the team concerning the adequacy, appropriateness and quality of all services provided to recipients including specific findings about individual recipients. 42 C.F.R. section 456.611. The district court found that, instead of making such detailed

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(f.n. cont.)
Federal Spending Practices and Open Government of the Comm. on Government Affairs, Assuring Quality of Care in Nursing Homes Participating in Medicare and Medicaid 186, 95th Cong., 2nd session (1978); Deficit Reduction Act of 1984, Conf. Rep. No. 861, 98th Cong. 2d session 1362 (1984).

findings and reports, DIM does not even attempt to assess the appropriateness of services. Hillburn, slip op. at 23; 65A.

It is quite clear from the above that DIM has not taken the federal inspection of care requirements seriously. While it is obvious to nonprofessionals that something is seriously wrong when persons with such severe disabilities spend their days lying on the floor in a nursing home without even such basic services as physical therapy and necessary adaptive equipment, DIM inspectors find nothing wrong because nursing home physicians do not order that adaptive wheelchairs or physical therapy be provided. State officials, in response to criticism from families and federal officials, blame each other for this inaction rather than cooperating in the development of a meaningful solution. The federal government has recognized that since SNF physicians may not understand the needs of retarded and severely physically handicapped persons, and has directed, through recent amendments to the state Medicaid Manual, that state reviewing teams determine whether appropriate professional judgments are being made by nursing home physicians. United States Department of Health and Human Services, Health Care Financing Administration State Medicaid Manual, section 4395,

transmittal No. 1, part 4 (October 26, 1982), and transmittal No. 19 (August, 1986).[11] These authoritative interpretations by the federal agency overseeing Medicaid are consistent with the federal scheme and underscore the correctness of the decision of the courts below.

III. THE COURT OF APPEALS' HOLDING THAT THE STATE MEDICAID AGENCY MUST TAKE EFFECTIVE CORRECTIVE ACTION WHENEVER A MEDICAID RECIPIENT'S NEED FOR AN ADAPTIVE WHEELCHAIR HAS NOT BEEN ADDRESSED BY THE SNF IN WHICH HE LIVES IS PLAINLY CONSISTENT WITH THE FEDERAL REGULATORY SCHEME AND THEREFORE NEED NOT BE REVIEWED BY THIS COURT.

The district court found that the state agency responsible for licensing and certifying SNFs participating in the Medicaid program, DHS, does not assess the appropriateness of the plan of care ordered by a resident's physician, and will not cite a SNF for a deficiency affecting only a single resident. Hillburn, slip op. at 22; 53A. The trial court also held that DIM patient review teams, like the DHS teams, do not look behind physician orders, and that DIM takes no action to compel the SNF to correct deficiencies affecting a single resident. Hillburn, slip op. at 23; 53A. The district court found that under this system no

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[11] State Medicaid Manual, section 4395, transmittal No. 1, part 4 (October 26, 1982) is attached to this brief as appendix A (app. A); State Medicaid Manual, section 4395, transmittal No. 19 (August, 1986) is attached as appendix B (app. B) to this brief.

single Connecticut official or agency is accountable for taking action to correct deficiencies affecting a single resident. The district court held that his inaction by DIM violated 42 C.F.R. section 456.613. It enjoined DIM to take "corrective action as needed" whenever medical review teams determining that a SNF had failed to adequately assess the need of Title XIX recipients for an adaptive wheelchair or failed to provide a needed adaptive wheelchair and related services. The court defined "corrective action as needed" to include those steps which the commissioner "deems reasonable" to ensure that skilled nursing facilities provide adaptive wheelchairs and related services to classmembers including, but not limited to, consultation with staff at the SNF, filing complaints with the appropriate medical staff at the SNF, filing complaints with the appropriate medical society and filing complaints with DHS.

DIM argues in its petition that it should be required to take no particular corrective action unless specifically mandated by the federal government. It points out that neither 42 C.F.R. section 456.613 or the Medical Assistance Manual, section 5-60-20 at p. 29 require specific corrective action, especially termination of provider agreements for irremediably noncompliant SNFs. Petition pp. 11,12,14. Connecticut's position on this issue is inconsistent with the Medicaid scheme of having the

program administered and supervised primarily at the state level.[12] Further, the state's protestations of powerlessness are "untenable" in the face of a specific regulatory requirement that the state Medicaid agency take corrective action, 42 C.F.R. 456.613, the terms of provider contracts which require each SNF to provide care and services in conformity with Title XIX, and the fact that under the federal regulatory scheme the state Medicaid agency is ultimately accountable for the implementation of the state plan in a manner consistent with the objectives of Medicaid. Hillburn, slip op. at 42, 43; 65A, 66A. The Court of Appeals affirmed this decision based primarily on the fact that the purpose of the requirement that the state designate a "single state agency" to administer its Medicaid program, see 42 U.S.C. section 1396 a(a)(5); 42 C.F.R. section 431.1 and 431.10 (1985), was to avoid a lack of accountability for appropriate operation of the program. 795 F.2d at 261.

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[12] The Commissioner's argument at page 3 of his petition that nursing homes should now be involved in the resolution of the issues raised by the litigation is suprising for two reasons: First, counsel for the state argued successfully against such participation in the district court and second, counsel for the Connecticut Association of Health Care Facilities, Inc., the law offices of Stephen E. Ronai, in a letter to the district court dated June 8, 1982, informed the Court that neither the association nor any other nursing home he represented wished to represent nursing homes during the trial of this matter.

As the court below notes, DIM's petition ignores the major thrust of the injunction entered against it. The judgment does not require DIM instantly to terminate a provider agreement upon a report of its review team that a SNF is not addressing the adaptive wheelchair needs of a particular resident. Indeed, given the practical and legal obstacles, provider agreements will continue to be rarely, if ever, terminated. Further, there are many options that will secure compliance short of termination which have never been carefully explored by DIM. DIM and DMR have already agreed, for example, to transfer some thirty classmembers from several SNFs to small properly supervised community residences in its court-approved implementation plan in C.A.R.C. v. Thorne, Civ. No. H78-653 (D. Conn., Consent Decree accepted April 9, 1984) because SNFs seem incapable of responding to the individual rules of classmembers. DIM has never vigourously pursued similar actions on behalf of other individual classmembers even though the federal statute and regulations contemplate such actions. See 42 U.S.C. section 1396 a(a)(31)(B); 42 C.F.R. 456.609 (b) and (c).[13] Further, the

[13] The United States Department of Health and Human Services, Health Care Financing Administration has taken the position in recent years that as a general rule, retarded persons should not be placed in nursing homes because such facilities are not equipped to identify or address their habilitative needs. (f.n. cont.)

interpretive guidelines of the federal agency charged with oversight of Medicaid state:

> If a patient is found by the review team to need services not available at the present facility, the single state agency should make arrangements for the provision of these services or transfer to a facility capable of providing them within a reasonable period of time. Medical Assistance Manual section 5-60-20, at 29, transmitted by MSA - PRG - 25 (11/12/72).

DIM may also initiate actions against nursing homes to enforce the provider contracts on behalf of an individual resident, may initiate disciplinary action against nursing home physicians who refuse to order necessary services, and recommend statutory and regulatory change at the state level to ensure that individuals are not lost in the shuffle. None of these actions require disruption of SNF residents who are not classmembers and who may be receiving adequate care. The regulations recognize, however, that DIM may terminate a provider agreement for "good cause" in the unlikely event a particular facility is irremediably

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(f.n. cont.)
has directed states to identify such persons through their inspection of care teams and transfer them to appropriate environments. United States Department of Health and Human Services, Health Care Financing Administration, State Medicaid Manual, section 4395, transmittal No. 1, part 4 (October 26, 1982) app. A, and transmittal No. 19 (August, 1986) app. B.

noncompliant.[14] 42 C.F.R. section 442.12(d). While termination of a provider is an extraordinary remedy, such action should be used when a SNF is indifferent to the health and safety of a particular resident or group of residents. The trial record in this case established that the failure to provide an adaptive wheelchair and related services has indeed created severe health and safety risks. Termination of a facility's provider agreement should be available if consultations with SNFs, patient transfers, and actions in state court or on the administrative level do not result in critical services being provided to classmembers in a reasonable time frame. The Court of Appeals' decision is therefore consistent with the plain language of the federal regulations and does not require review by this court.

Connecticut's argument that the decision of the Second Circuit conflicts with prior decisions of this court is also no basis for review by this court. Indeed, the state admits on page 13 of its petition that the decision of the Second Circuit does

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[14] The petitioner has cited no statute or regulation that is inconsistent with this part of the judgment. Congress intended the independent medical review requirements, 42 U.S.C. section 1396 a (a)(31), and the facility certification requirement, 42 U.S.C. section 1396a(a)(33) to stand side-by-side and to be (f.n. cont.)

not "squarely conflict" with the decisions of this Court or any lower court. O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980) and the lower court decisions cited by the petitioner simply do not address the issues raised in the decisions of courts below.

Connecticut's argument that the remedial orders entered by the district court are impermissibly broad also provides no compelling basis for review by this Court. The district court orders do not require sweeping remedial relief. They require only that the state Medicaid agency implement the federal regulatory requirements at 42 C.F.R. part 456, Subpart I and 42 C.F.R. section 442.12(d), to the extent necessary to determine whether SNFs are appropriately identifying each classmember's needs for an adaptive wheelchair and "related services" and are providing such equipment and services when appropriate. The

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(f.n. cont.)
implemented by the states so as to protect each Title XIX recipient's physical well-being. The function of the single state agency requirement is to make these and other Medicaid requirements operate together to improve patient care. The State Medicaid Agency should have the threat of provider agreement termination in its arsenal of remedial tools to secure prompt compliance on behalf of individual classmembers.

judgment does not, for example, require DIM teams to determine whether the services available to each classmember are adequate to promote his maximum potential as is required by 42 C.F.R. section 456.609. It does not, therefore, go so far as to mandate that each classmember's need for physical therapy, theraputic feeding or programming to reduce the use of restraint or psychotropic medications be identified by the DIM teams or that DIM take corrective action where such obvious inadequacies exist. The orders of the district court are, therefore, narrower than plain requirements of the federal regulations. Such limited orders are not impermissibly broad as they require extensive remedial relief less extensive than the violations of rights established at trial and recognized by the Courts below. Milliken v. Bradley, 433 U.S. 267, 280, 281 (1977).

IV. PETITIONER HAS WAIVED HIS CLAIM THAT THE APPLICABLE MEDICAID REGULATIONS ARE UNENFORCEABLE UNDER 42 U.S.C. SECTION 1983.

The Commissioner argues, at pages 15-21 of his petition that the federal regulations set out at 42 C.F.R. Part 456, Subpart I are unenforceable under 42 U.S.C. section 1983. The defendant conceded in his brief to the court of appeals, however, that this argument was first raised in his post trial memorandum. Rule 12(h)(2) of the Federal Rules of Civil Procedure provides that

the defense of failure to state a claim upon which relief may be granted must be raised before the close of trial. Wright and Miller, Federal Practice and Procedure, section 1392 at 862; Simpson v. Alaska State Commission for Human Rights, 608 F.2d. 1171, 1174 (9th cir. 1979). Thus, the defense may not be raised for the first time in a post-trial motion, Black, Sivalls and Bryson v. Shondell, 174 F.2d 587, 591 (8th cir. 1949), or on appeal, Smith v. Atlas Off-Shore Boat Service, Inc., 653 F.2d 1057, 1059, n.1 (5th cir. 1981); Brule v. Southworth, 611 F.2d 406, 409 (1st cir. 1979).[15] Since the defendant has waived this claim it should not be considered by this Court.

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[15] Even if this issue is properly presented, this case need not be reviewed as plaintiffs have a private cause of action under the prior decisions of this Court. Maine v. Thiboutot, 448 U.S.1 (1980); Miller v. Youakim, 440 U.S. 125, 132 n.13 (1979), Quern v. Mandley, 436 U.S. 725, 729 n.3 (1973). The defendant argues, however, relying principally upon O'Bannon v. Town Court Nursing Center, Inc., 447, U.S. 773 (1980), that Medicaid recipients cannot sue under 42 U.S.C. section 1983 to address the deprivation of indirect benefits. This case is, however, clearly distinguishable. First, the defendant Commissioner has known for nearly a decade of the need of plaintiff classmembers for adaptive wheelchairs and related services, yet has failed to take action to implement the mandatory requirements of 42 C.F.R. Part 456, Subpart I. In these circumstances governmental action has encouraged and fostered the SNFs failure to protect the classmembers' health and safety. Governmental action on these facts has directly contributed to the violations of plaintiffs' rights. Second, unlike the risks associated with patient (f.n. cont.)

V. CONCLUSION

For the foregoing reasons this Court should not issue a Writ of Certiorari to the Court of Appeals for the Second Circuit as requested by the State of Connecticut.

(f.n. cont.)
transfers incurred by the O'Bannon plaintiffs, the severe health risks to which these plaintiffs have been subjected were never contemplated by Congress. Third, O'Bannon involved an effort by Medicaid recipients to interfere with proper governmental enforcement of Medicaid. 447 U.S. at 787, 788. This case, on the other hand, involves a failure of state government to exercise its lawful obligation to implement the medical review requirements of the federal law. The plaintiffs have sought and obtained orders that require the Commissioner to begin proper supervision of nursing homes consistent with the Medicaid requirements. These orders do not interfere with proper enforcement efforts - they only mandate that the federal requirements be honored.

Respectfully submitted,

David C. Shaw
Trowbridge, Ide & Greenwald, P.C.
216 Main Street
Hartford, CT 06106
(203) 249-9321

APPENDIX A:

STATE MEDICAID MANUAL
Section 4395, Transmittal No. 1
Part 4 (October 26, 1982)

STATE MEDICAID MANUAL
PART 4 - SERVICES

Department of Health
and Human Services
Health Care Financing
Administration

Transmittal No. 1 Date October 1982

NEW MATERIAL	PAGE NO.	REPLACED PAGES
Table of Contents	4-1 (1 p)	———
Section 4395	4-1 (1 p)	———

This is the first issuance in Part 4 of the State Medicaid Manual.

NEW POLICY--EFFECTIVE DATE: October 26, 1982

Section 4395, Inappropriate Placement of Mentally Retarded Persons in SNFs and ICFs.--This section emphasizes the need for appropriate placement of mentally retarded persons in SNFs and ICFs to satisfy their developmental needs.

4395 INAPPROPRIATE PLACEMENT OF MENTALLY RETARDED PERSONS IN SNFs AND ICFs

It has been estimated that up to 10 percent of the residents of SNFs and ICFs are mentally retarded persons. The appropriateness of many of these placements has been challenged by groups who represent these individuals. These groups are concerned that many retarded persons in general care facilities are not receiving the developmental services they need.

Inappropriate placement may result from inadequate evaluation, incorrect diagnosis, or lack of needed programs or facilities. When inappropriate placements continue to be made because of the absence of suitable alternative care, this removes much of the incentive to develop those alternatives. These problems have been compounded by pressures to deinstitutionalize the residents of large facilities. The developmental needs of mentally retarded persons place a particularly compelling responsiblity on the facilities, inspection of care teams, and facility surveyors to assure that the placement of these individuals is appropriate and that needed services are, in fact, delivered.

This section emphasizes the need for appropriate placement required to satisfy the developmental needs of mentally retarded individuals in SNFs and ICFs. If the primary need of a mentally retarded person is active treatment for his/her retardation, then the person should ideally be certified for ICF/MR care. If the primary need for care is medical, then the person may appropriately be placed in a SNF or ICF.

It should be stressed that even when the primary needs of retarded persons in SNFs or ICFs are medical, their developmental needs must still be met by the facility in the context of the individual's overall physical condition. 42 C.F.R. 442.306 specifies that an ICF must insure admission of only those individuals whose needs can be met by the ICF itself, by the ICF in cooperation with community resources, or by the ICF in

cooperation with other providers of care. 42 C.F.R. 456.609 indicates that the inspection of care team must determine whether the services available in the facility are adequate to meet the health, rehabilitative, and social needs of each resident and to promote his/her maximum physical, mental, and psychosocial functioning. If a facility is not able to provide the services either directly or under an arrangement with an outside source, mentally retarded individuals in need of such care should not be admitted to the facility.

APPENDIX B:

STATE MEDICAID MANUAL
Section 4395, Transmittal No. 19
Part 4 (August, 1986)

STATE MEDICAID MANUAL
PART 4 - SERVICES

Department of Health
and Human Services
Health Care Financing
Administration

Transmittal No. 19 Date August 1986

NEW MATERIAL	PAGE NO.	REPLACED PAGES
Sec. 4395	4pp.	4pp.

CLARIFICATION - EFFECTIVE DATE: Not Applicable

Section 4395, Inappropriate Placement of Mentally Retarded Persons....
This section is expanded to include more specific guidance for evaluating the appropriateness of nursing home placement of retarded persons....

4395. INAPPROPRIATE PLACEMENT OF MENTALLY RETARDED PERSONS IN SNFs AND ICFs.

It has been estimated that up to 10 percent of the residents of SNFs and ICFs are mentally retarded persons. The appropriateness of many of these placements has been challenged by groups who represent these individuals. These groups are concerned that as a result of inappropriate placement many retarded persons in general care facilitites are not receiving the developmental services they need.

Inappropriate placement may result from inadequate evaluation, incorrect diagnosis, or lack of needed programs or facilities. When appropriate placements continue to be made because of the absence of suitable alternative care, this removes much of the incentive to develop those alternatives. These problems have been compounded by pressures to deinstitutionalize the residents of large facilities. The developmental needs of mentally retarded persons place a particularly compelling responsiblity on the facilities, inspection of care teams and facility surveyors to assure that the placement of these individuals is appropriate and that needed services are, in fact, delivered.

This section emphasizes the need for appropriate placement to satisfy the developmental needs of mentally retarded individuals. If the primary need of a mentally retarded person is active treatment for his/her retardation, then the person should be placed in an ICF/MR. Chronically handicapped persons who are stable but who have severe disabilities have sometimes been placed in nursing homes not because their conditions preclude them from living in another environment but because continued coverage under Medicaid is sought.

Only a small percentage of mentally retarded persons would appropriately be placed in SNFs. This group would include these individuals whose physical condition requires skilled medical care on an inpatient basis that cannot be provided in an ICF/MR or other type of facility or home. It should be stressed that even when the primary needs of retarded persons in SNFs are

medical, their developmental need must still be met by the facility to the extent allowed by the individual's overall physical condition. In most cases, however, if their medical needs are so great that SNF care is required, the patients will not generally be well enough to receive a typical program of a wide spectrum of developmental training, especially if it is provided outside the facility. In such cases, the facility must still aggressively pursue those areas of intervention needed, (e.g. sensory stimulation, range of motion, toilet training as possible). A patient well enough to attend outside training would nearly always be well enough to be placed in an ICF/MR or other appropirate setting. 42 CFR 456.609 indicates that the inspection of care team must determine whether the services available in the facility promote the patient's maximum physical, mental and psychosocial functioning. If retarded residents are not receiving the care described above, this requirement would result in a negative inspection of care finding. Continued general acceptance of the inappropriate placement of retarded persons in nursing homes is unacceptable.

Another small group that may appropriatley be placed in a general care facility would include those mentally retarded persons of advanced age for whom developmental training is no longer appropriate. These persons may appropriately be placed at an ICF if institutional care is required. This decision must be made on an individual basis rather than at an arbitrary age because some elderly retarded persons receive benefits from continued developmental services.

Providers should be aware that failure to comply with the above mentioned regulation governing the appropriate placement of mentally retarded persons in SNFs and ICFs could affect Federal reimbursement. Utilization Review is a State plan requirement and disallowance of payment may be made to correct this problem; inappropriate placement may also jeopardize the "approved" status of a State plan. Section 2363 of the Deficit Reduction Act of 1984 (Public Law 98-369) has altered the requirements relating to UC penalties and has made some items previously subject to UC penalties (i.e. certification and recertification of the need for care, plan of care, and utilization review) State plan requirements not subject to the penalties. However, these requirements may still be the subject of disallowances. Utilization Control penalties are also still in place under the inspection of Care provision and such penalties may be imposed where findings of inappropriate placements have been cited and not corrected.

NO. 86-747

In the Supreme Court of the
United States

October Term, 1986

STEPHEN B. HEINTZ, COMMISSIONER,
CONNECTICUT DEPARTMENT OF
INCOME MAINTENANCE,

Petitioner

v.

DALE HILLBURN, by his parents and
next friends, Ralph and Eleanor
Hillburn, et al,

Respondents

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Second Circuit

CERTIFICATE OF SERVICE

Attorney David C. Shaw, Counsel of Record for Dale Hillburn et al, and a member of the Bar of the Supreme Court of the United States, hereby certifies that on this 4th day of December, 1986, copies of Respondents' Brief in Opposition to Petition for a Writ of Certiorari were mailed, first-class, postage prepaid, to: Hugh Barber, Esq., Assistant Attorney General, 90 Brainard Road,

Hartford, Ct 06114, Attorney Shelley White, Connecticut Civil Liberties Union, 32 Grand Street, Hartford, CT 06107; Janey Bell, Esq., Legal Aid Society, 525 Main Street, Hartford, CT 06103; and R. Jeffrey Sands, Esq., Wiggin & Dana, Esqs., 195 Church Street, New Haven, CT 06510, Stephen Ronai, Esq., Murtha, Cullina, Richter and Pinney, CityPlace, Hartford, CT 06106.

I hereby certify that all parties required to be served have been served.

David C. Shaw
Trowbridge, Ide & Greenwald, P.C.
216 Main Street
Hartford, CT 06106
(203) 249-9321

No. 86-747

In The Supreme Court Of The United States

OCTOBER TERM, 1986

STEPHEN B. HEINTZ, Commissioner of the Connecticut Department of Income Maintenance,
Petitioner,

v.

DALE HILLBURN, by his parents and next friends Ralph and Eleanor Hillburn, et al.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY BRIEF OF THE PETITIONER, STEPHEN B. HEINTZ, COMMISSIONER OF THE CONNECTICUT DEPARTMENT OF INCOME MAINTENANCE IN SUPPORT OF THE GRANT OF CERTIORARI

JOSEPH I. LIEBERMAN
Attorney General

HUGH BARBER
Assistant Attorney General
Counsel of Record
90 Brainard Road
Hartford, CT 06114
(203) 566-7098

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REPLY BRIEF OF THE PETITIONER, STEPHEN B. HEINTZ, COMMISSIONER OF THE CONNECTICUT DEPARTMENT OF INCOME MAINTENANCE IN SUPPORT OF THE GRANT OF CERTIORARI

The petitioner, Stephen B. Heintz, Commissioner of the Connecticut Department of Income Maintenance, files this reply brief in support of the grant of certiorari in order to respond to the claim raised in the respondents' brief in opposition that the petitioner has waived his claim that the inspection of care obligations of 42 U.S.C. § 1396a(a)(31) are not privately enforceable by a § 1983 cause of action. Contrary to the representations in respondent's brief at p. 21, the defense of failure to state a claim upon which relief can be granted

was raised in the petitioner's answer as his second defense, Appendix A, and was fully briefed in his trial memorandum, Appendix B, which trial memorandum was filed well before closing oral argument and the rendition of judgment on the merits by the district court.

Rule 12(h)(2) of the Federal Rule of Civil Procedure provides that a defense of failure to state a claim upon which relief can be granted "may be made in any pleading permitted or ordered under Rule 7(a), or by motion for judgment or the pleadings, or at the trial on the merits." The purpose of the rule is to *preserve* the enumerated defenses, notwithstanding a failure to assert the defense in a prior 12(b) filing. Wright and Miller, Federal Practice and Procedure, § 1392.

In addition to preserving the enumerated defenses notwithstanding the prior filing of a 12(b) motion, the rule favors the enumerated defenses by allowing them to be asserted either by motion, by pleading or "at the trial on the merits." The cases cited by the respondents in their brief in opposition only stand for the proposition that the defense must be asserted prior to a disposition on the merits by the trial court. For example, in *Black, Sivalls and Bryson v. Shondell,* 174 F.2d 587, 591 (8th Cir. 1949) cited by the respondents at p. 21, it was held that the failure to assert the defense until the filing of a motion for judgment notwithstanding the verdict (after the disposition on the merits by the jury) waived the defense. The authority cited by the respondent simply does not support a claim of waiver when the defense was asserted in the answer and was fully articulated in the petitioner's trial memorandum.

Furthermore, the issue was squarely presented to the court of appeals as an issue presented for review. Petitioner's Appellate Brief to the Second Circuit Court of Appeals at pp. 1, 46–49; Petitioner's Reply Brief to the Second Circuit Court of Appeals at pp. 12–23; Petitioner's Petition for Rehearing to the Second Circuit Court of Appeals at pp. 1, 2. In short, the issue was raised before the district court and the court of appeals and is properly presented to for review.

In closing, we note that the balance of the respondents' brief in opposition demonstrates the need for this Court to grant a writ of certiorari in order to review the decision below. Essentially, the respondents argue that the court below correctly interpreted the Medicaid Act as requiring that the "single state agency" be accountable for ensuring that every Title XIX assisted patient in skilled nursing facilities receive the services that he requires. The respondents further argue that the court below properly held that the petitioning Commissioner of Connecticut's single state agency must take whatever "corrective action" is required to achieve that result, including termination of qualified (i.e., certified) facilities from the program. The respondents, and the court below, however, rely entirely on general provision in the Act pertaining to the administrative responsibilities of the single state agency. The respondents, and the Court below, continue to ignore the specific provisions in the Act which place the responsibility for establishing and maintaining institutional standards, and for determining whether or not nursing facilities are qualified to participate, upon the state health inspection agency. 42 U.S.C. § 1396a(a)(9); 42 U.S.C. § 1396a(a)(33).[1] Certiorari

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[1] The respondents profess surprise at p. 15, fn. 12, of their reply brief at the position articulated by the petitioner that the skilled nursing facilities and the state health inspection agency should participate in litigation addressed to the adequacy of quality of care enforcement. As noted by the district court, the bounds of this litigation have been slippery and difficult to determine. Pet. App. 42A. The complaint filed by the plaintiffs appeared to only state a challenge to the petitioner's methodology of reimbursement for the cost of adaptive wheelchairs under the Medicaid program. Pet. App. 41A. At one point in time the petitioner did oppose certification of a defendant class of skilled nursing facilities; however, when it became apparent that the plaintiffs intended to address quality of care enforcement issues, the petitioner moved to dismiss this action in the district court for failure to join the skilled nursing facilities and the state health inspection agency. Motion to Dismiss Pursuant to Rules 12 and 19, denied December 7, 1983.

Consistently, throughout this litigation, the petitioner has contended that the state health inspection agency is responsible for quality of care enforcement. Both the district court and the court of appeals (erroneously) addressed the issue of the relative responsibility of the single state agency

(continued)

should issue in order for this Court to resolve this issue of considerable importance to the State and to its Title XIX-assisted patients of participating skilled nursing facilities.

Respectfully submitted,

JOSEPH I. LIEBERMAN
Attorney General

HUGH BARBER
Assistant Attorney General
Counsel of Record

90 Brainard Road
Hartford, CT 06114
Tel. (203) 566-7098

Counsel for Petitioner

---

[1] *(continued)*

for quality of care enforcement vis-a-vis the state health inspection agency. Respondents' professed surprise is, therefore, quite misleading.

APPENDIX A

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DALE HILLBURN, ET AL,	*	
Plaintiffs,	*	
V.	*	CIVIL NO. 82-200
EDWARD MAHER, ET AL,	*	
Defendants.	*	
	*	OCTOBER 28, 1982

ANSWER OF THE DEFENDANT, EDWARD MAHER, COMMISSIONER OF THE CONNECTICUT DEPARTMENT OF INCOME MAINTENANCE

FIRST DEFENSE

1. Said defendant denies all of the allegations contained in paragraphs 8 and 12 of the plaintiffs' complaint.

* * *

SECOND DEFENSE

The complaint fails to state a claim upon which relief can be granted.

APPENDIX B

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DALE HILLBURN, et al, Plaintiffs, vs. COMMISSIONER, CONNECTICUT DEPARTMENT OF INCOME MAINTENANCE, et al, Defendants.	:	CIVIL NO. H82-200
	:	JULY 6, 1984

TRIAL MEMORANDUM OF THE COMMISSIONER, DEPARTMENT OF INCOME MAINTENANCE

(page 14)

III. PRINCIPLES OF LAW WHICH ARE APPLICABLE TO PLAINTIFFS' STATUTORY CLAIM.

A. Rules Of Statutory Construction

It is clearly established if a state elects to participate in a federal-state cooperative grant program, that the state is not obligated to implement all of the "goals" or "objectives" of the program but may only be required to provide those services that are *mandatory upon the state as a condition of participation. Quern v. Mandley,* 436 U.S. 725 (1978); *Beal v. Doe,* 432 U.S. 438 (1977); *Pennhurst State School v. Halderman,* 451 U.S.1 (1981).

(page 14 continued)

Moreover, the legitimacy of federal legislation enacted pursuant to Congress' Spending Power ". . . rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' " *Pennhurst State School v. Halderman, supra,* p. 17.

> "There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. . . . By insisting that Congress speak with a clear voice, we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation." *Id.*

Thus, in order to prevail on their statutory claim, the plaintiffs must show that the Act clearly and unambiguously imposes mandatory obligations upon the defendant in its administration of Connecticut's Title XIX Medicaid program, which this defendant has failed to comply with to the detriment of the plaintiff class.

B. Availability Of A Cause Of Action

Assuming that Title XIX of the Social Security Act, 42 U.S.C. § 1396a *et seq.,* clearly and unambiguously imposes mandatory obligations upon this defendant which this defendant has breached to the plaintiffs' detriment, the plaintiffs must also show that a cause of action is available to them to redress the violation. Prior to *Maine v. Thiboutot,* 448 U.S. 1 (1980), it was unclear whether § 1983 was available to provide a cause of action for the enforcement of purely statutory federal rights (or if § 1983 was limited to the enforcement of constitutional claims). In *Maine v. Thiboutot,* however, the Supreme Court interpreted the "and laws" provision of § 1983 as allowing for a cause of action to enforce federal statutes against state officials acting "under color of" state law.

The Supreme Court, however, promptly retreated from its *Thiboutot* decision by formulating a two-tier test which must be met before § 1983 can be available to enforce a federal statute. That test was initially announced in *Pennhurst State School and Hospital v. Halderman, supra,* and subsequently restated in *Middlesex County Sewerage Authority,* 101 S.Ct. 2615 (1981).

In *Pennhurst,* the Supreme Court first noted that the statutory rights alleged must be the sort of "rights secured" by the laws of the United States within the meaning of § 1983. *Pennhurst, supra,* p. 28. The Supreme Court then noted that § 1983 may not be available "where the governing statute provides an exclusive remedy for violations of the Act." *Id.*

The two-tier test announced in *Pennhurst* was subsequently reiterated in *National Sea Clammers* when the Court noted:

> "The Court . . . has recognized two exceptions to the application of § 1983 to statutory violations. In *Pennhurst State School and Hospital v. Halderman,* _____U.S._____ (1981), we remanded certain claims for a determination (i) whether Congress had foreclosed private enforcement of that statute in the enactment itself, and (ii) whether the statute at issue was the kind that created enforceable rights under § 1983. 101 S.Ct. at 2625-26.

Moreover, in order for a statute to create "enforceable rights under § 1983," it is clear that the statute must create "individual rights." *National Sea Clammers, supra; Pennhurst, supra; Garrity v. Gallen,* 522 F. Supp. 171 (D.N.H. 1981).

Wherefore, in order to prevail on each of plaintiffs' Social Security Act claims, the plaintiffs must show that the statute creates *"individual rights"* under § 1983 and the statute does not provide for exclusive remedies. Because plaintiffs' claims arise out of different sections of the Social Security Act, the availability of a cause of action will be discussed separately for each statutory claim as part of subsequent sections of this memorandum.

* * *

B. A Cause Of Action Is Not Available To Enforce The Periodic Inspection Of Care Requirement.

Although one of the requirements that the state plan must meet is an explanation of how the "professional review team" will evaluate "the adequacy of the services available in particular skilled nursing facilities to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities," no *statutory mechanism exists for the single state agency to deny payment to a certified provider because of a finding that a particular recipient did not receive SNF services* in accordance with the provisions of the Act. The Act merely requires the state plan to provide for the transmittal of "the findings resulting from such inspections, together with any recommendations, to the State agency administering or supervising the administration of the State plan." 42 U.S.C. § 1396a(a)(26).

Regulations of HHS are in accord in that the regulations provide that "the purpose of this review plan is to provide guidance to the Medicaid agency in the administration of the State plan, and where applicable, to the State licensing agency described in § 431.610." 42 C.F.R. 456.6(b) (emphasis added). Specifically concerning findings of inadequate care at skilled nursing facilities, HHS regulations in Title 42 only require that:

> § 456.612 Copies of reports
> The agency must send a copy of each report to — . . .
> (c) The agency responsible for licensing, certification, or approval of the facility for purposes of Medicare and Medicaid.
> 456.613 Action on reports
> The agency must take corrective action as needed based on the report and recommendations of the team submitted under this sub-part.

Although the above-cited regulation obscurely provides for the single state agency to "take corrective action as

needed,"* there is no authority in the Act for the state agency to terminate payment to a certified provider because of a finding of a professional review team. Nor is there any authority in the Act for the single state agency to direct an unwilling medical provider to provide a desired service for a particular patient [the provider must first "undertake to provide the service," 42 U.S.C. 1396a(a)(23)].

The foregoing analysis demonstrates that 42 U.S.C 1396a(a)(26) and 42 C.F.R. § 456.609 and § 456.610 do not create "personal rights" enforceable by § 1983, but are only intended to indirectly benefit Title XIX patients by promoting quality of care and by providing ". . . guidance to the Medicaid agency in the administration of the State plan and, where applicable, to the State licensing agency described in § 431.610."**

Furthermore, the second test on the availability of a cause of action is also not met since the Act explicitly provides for penalties that may be imposed upon the states as a result of ineffective periodic inspections — namely, a reduction of the federal medical assistance percentage that would otherwise be due to the State. 42 U.S.C. § 1396b(g). The record in this case indicates that the federal government implements its 42 U.S.C. § 1396b(g) disallowance authority by periodically assessing the Department's compliance and by taking disallowances, as appropriate F. XII-8.

* * *

---

* The agency has taken corrective action, to the extent of its authority, by reviewing the findings with the facility, monitoring the facility's correction of deficiencies and by forwarding copies of the reports to the Connecticut Department of Health Services — the state health inspection agency.

**42 C.F.R. § 431.610 concerns the responsibility of the state health inspection agency to conduct surveys and certifications. This reference reinforces our position that survey and certification is the *exclusive* methodology authorized by the Act to take action against a facility for reasons of inadequate care.

(2)

No. 86-747

IN THE

Supreme Court of the United States

October Term 1986

STEPHEN B. HEINTZ, Commissioner of the Connecticut Department of Income Maintenance,

Petitioner,

against

DALE HILLBURN, by his parents and next friends Ralph and Eleanor Hillburn, *et al.*,

Respondents.

MOTION FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INCORPORATED IN SUPPORT OF THE COMMISSIONER'S PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

STEPHEN E. RONAI
H. KENNEDY HUDNER
(Counsel of Record)
MARTHA EVERETT MENG

MURTHA, CULLINA, RICHTER AND PINNEY
CityPlace — P.O. Box 3197
Hartford, Connecticut 06103-0197
(203) 240-6000

Counsel for *Amicus Curiae*

28 pp

Questions Presented

1. Under Title XIX of the Social Security Act (Medicaid), must termination of a provider agreement for deficiencies in quality of care be based on non-compliance with federal quality-of-care standards as determined by the state survey and certification agency?

2. Does Title XIX of the Social Security Act require the single state agency responsible for administration of the state's Medicaid plan to review the plan of care developed for each Medicaid patient by his or her personal physician in order to assess the adequacy of the plan itself?

3. Is the obligation of the single state agency to review the adequacy of care provided to Title XIX-assisted patients, and to take corrective action as needed, enforceable by a private cause of action pursuant to 28 U.S.C. § 1983?

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IN THE
SUPREME COURT OF THE UNITED STATES

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No. 86-747

STEPHEN B. HEINTZ, Commissioner of the Connecticut Department of Income Maintenance,

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The Connecticut Association of Health Care Facilities, Inc. ("CAHCF") hereby requests permission of this Court to file its brief as *amicus curiae* in support of the Petition of the Connecticut Commissioner of Income Maintenance for a Writ of Certiorari to the Second Circuit Court of Appeals. The Commissioner of Income Maintenance and New Brook Hollow Health Care Center, Inc. have consented to the filing of the brief. Letters from counsel for the Commissioner and for New Brook Hollow are filed together with this Motion. The named plaintiffs, Dale Hillburn, James Corbett, Sandra Fuchs, Stephen Kaplanka and Mark Kaplanka have withheld their consent. Therefore, CAHCF moves that leave to file a brief as *amicus curiae* be granted by this Court.

At issue in this case is the proper construction of provisions of Title XIX of the Social Security Act ("Medicaid"), 42 U.S.C. § 1396 *et seq.*, and regulations promulgated thereunder governing the basis for a state's termination of agreements with providers who render care and services to Medicaid-assisted patients. The Judgment of the District Court in this case requires the Connecticut Department of Income Maintenance ("CDIM") to terminate provider agreements with skilled nursing facilities ("SNFs"), under certain circumstances, based on reports of CDIM's Medical Review Teams regarding inadequate care. Termination is required even though the SNF has been and continues to be certified by the state's Certification Agency as being in compliance with all federal quality-of-care standards. It is the position of the Commissioner, and of CAHCF, that under the Act termination of provider agreements because of inadequate care must be based on the comprehensive review of compliance with federal health care standards conducted by the Certification Agency, not on reports of CDIM's Medical Review Teams.

CAHCF is a non-profit membership association of approximately one hundred seventy-five providers of health care services to patients in need of long-term nursing home care. Over ninety percent of its members are SNFs that have provider agreements with CDIM to render care and services to Medicaid-assisted patients and to receive payment for such care and services. All of these members are affected, actually or potentially, by the Judgment of the District Court. In addition, several hundred SNFs in states within the Second Circuit potentially are affected by that Court's affirmance of the Judgment. At least forty-nine states participate in the federal-state cooperative Medicaid program. If the holding of the Second Circuit is followed, the construction of the Act at issue in this case will affect thousands of providers throughout the country.

As a result of the Judgment, CAHCF's member SNFs are placed squarely in the midst of conflicting determinations by two state agencies. One, the Certification Agency, serves as the designee

of the Secretary of Health and Human Services in conducting reviews of compliance with the numerous and detailed federal health care standards (which include state licensure) called the Conditions of Participation. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 405.1101-.1137; 42 C.F.R. § 405.1901 *et seq.* CDIM, through its Medical Review Teams, has the more limited responsibility of assessing the "adequacy of care" provided to individual Medicaid-assisted patients: no more specific standards for the Teams' reviews have been set forth either in statute or by regulation. 42 U.S.C. § 1396a(a)(31)(B); 42 C.F.R. § 456.610 *et seq.* Yet pursuant to the Judgment, the CDIM must terminate an SNF provider agreement on the basis of "inadequate" care, even though the SNF has been found by the Certification Agency to meet all of the Conditions of Participation.

The practical consequences of termination of a provider agreement are devastating. In Connecticut, approximately sixty-five percent of SNF residents receive Medicaid assistance. Termination of a Medicaid provider agreement therefore will result in at least substantial economic loss to and, in most cases, the forced closing of the facility. Termination also requires the transfer of all Medicaid-assisted patients. To permit such results to arise from the findings of the Medical Review Teams is inconsistent with the states' sound and efficient administration of their Medicaid programs and the purposes and policies underlying the Act.

It is important that the consequences of the District Court's Judgment be considered from the perspective of the SNFs participating in the Medicaid program. Although the Judgment imposes a heavy administrative burden on the CDIM, its impact will be most fully and severely experienced by providers. Therefore, CAHCF urges this Court to consider the views of its member health care providers in its decision regarding review.

Conclusion

Because CAHCF has a substantial interest in this case and because its brief will provide a perspective on the issue before this Court that supplements the concerns expressed by the CDIM, this motion for leave to file its brief as *amicus curiae* should be granted.

Respectfully submitted,

STEPHEN E. RONAI
H. KENNEDY HUDNER
(Counsel of Record)
MARTHA EVERETT MENG

MURTHA, CULLINA, RICHTER AND PINNEY
CityPlace — P.O. Box 3197
Hartford, Connecticut 06103-0197
(203) 240-6000

Counsel for *Amicus Curiae*

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BRIEF OF *AMICUS CURIAE* CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INCORPORATED IN SUPPORT OF THE COMMISIONER'S PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Statement of Interest and Summary of Argument

A. Statement of Interest

The Connecticut Association of Health Care Facilities, Inc. ("CAHCF") is a non-profit membership association of approximately one hundred seventy-five providers of health care services to patients in need of long-term nursing home care. Over ninety percent of its members are skilled nursing facilities that have entered into agreements ("provider agreements") with the State of Connecticut Department of Income Maintenance ("CDIM") to provide care and services to patients receiving assistance under Title XIX of the Social Security Act and to receive payment from CDIM for such care and services. All of these members are affected, actually or potentially, by the Order of the District Court

requiring CDIM to terminate provider agreements,[1] under certain circumstances, based on reports by CDIM's Medical Review Teams. In order to understand the interest of CAHCF's member facilities in this matter, one must first understand the statutory and regulatory framework governing quality-of-care determinations and termination of provider agreements.

1. CDIM, the "single state agency."

Title XIX of the Social Security Act ("Medicaid"), 42 U.S.C. § 1396 *et seq.*, is a cooperative federal-state program designed to assist eligible individuals with the cost of necessary medical services. Each state participating in the Medicaid program must designate a single state agency—in Connecticut, the Department of Income Maintenance ("CDIM")—as responsible for the general administration of its Medicaid plan. 42 U.S.C. § 1396a (a)(5).

2. Certification Agency.

In addition to the single state agency, the state must designate a *separate* state agency—in Connecticut, the Connecticut Department of Health Services ("Certification Agency")—as responsible for the oversight of health care standards in institutions serving Medicaid patients. 42 U.S.C. § 1396a(a)(9)(A).

This state health agency must be the same agency designated by the Secretary of Health and Human Services (the "Secretary") under Title XVIII of the Social Security Act ("Medicare") to inspect the adequacy and quality of institutional care and to certify institutional providers as eligible for participation in the Medicare program. 42 U.S.C. § 1395aa(a); 42 U.S.C. § 1396a(a)(9)(A);

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[1]CAHCF has chosen to address fully only the first of the three Questions presented as that Question most directly affects its members. CAHCF also supports the Petitioner's request for review of the second and third Questions presented but believes the reasons for requesting review are addressed adequately in the Petitioner's Brief.

42 C.F.R. § 405.1901 *et seq.;* 42 C.F.R. § 431.610(b). The Certification Agency also performs the survey and certification function for purposes of the Medicaid program. 42 U.S.C. § 1396a(a)(33)(B); 42 C.F.R. § 431.610(b) and (e). Institutional providers who are certified as eligible by the Certification Agency may enter into Medicare provider agreements with the Secretary and Medicaid provider agreements with the single state agency (here, CDIM) in order to receive payments under these programs. 42 U.S.C. § 1395cc(a); 42 U.S.C. 1396i; 42 C.F.R. § 442.10 *et seq.*

3. Skilled Nursing Facility ("SNF").

SNFs are one type of long-term care provider that may be certified by the Certification Agency. The quality-of-care standards for certification as an SNF under Medicare and Medicaid are identical. Under both programs, in order to enter into a provider agreement, an SNF must comply with the comprehensive quality-of-care standards called Conditions of Participation. 42 U.S.C. § 1395x(j)(15); 42 U.S.C. § 1396a(a) (28); 42 C.F.R. § 405.1101-.1137; 42 C.F.R. § 431.610(f)(1). An SNF that has been certified by the Certification Agency as eligible to participate in Medicare is automatically eligible to participate in Medicaid.[2] 42 U.S.C. § 1396i; 42 C.F.R. § 442.12(a).

4. Conditions of Participation.

The Certification Agency conducts exhaustive on-site inspections on at least an annual basis for the purpose of certifying whether an SNF meets the federal Conditions of Participation for Medicare and Medicaid. 42 C.F.R. § 405.1902-.1904; 42 C.F.R.

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[2]In the case of Intermediate Care Facilities and the very small number of SNFs that have Medicaid but not Medicare provider agreements, the Certification Agency certifies eligibility for payment directly to the single state agency. 42 C.F.R. § 442.101(a) and (c). Virtually all of CAHCF's member SNFs have both Medicaid and Medicare provider agreements and are subject to dual certification.

§ 431.610. The Conditions, which set precise standards for all areas of institutional functioning and patient care, include 87 "Standards," which have been further subdivided into several hundred "Factors."[3] 42 C.F.R. § 405.1101-.1137; HCFA Survey Forms 519 and 525. These separate Factors are addressed by the Certification Agency during the inspection process. In certifying a facility, the Certification Agency also must consider the supplemental reports of CDIM's Medical Review Teams (see page 5 *infra*) and any other reports pertaining to the health and safety of patients. 42 C.F.R. § 405.1904(b)(2) and (3); 42 C.F.R. § 431.610(g)(1)(i).

5. Sanctions triggered by the Certification Agency report.

If at any time the Certification Agency finds that a facility does not meet the requirements for certification, it must notify the Secretary. 42 C.F.R. § 405.1905(a). The Secretary may then: (a) continue the provider agreement on a conditional basis; (b) deny payment for new admissions; or (c) terminate the provider agreement. 42 U.S.C. § 1395cc(f)(1); 42 C.F.R. § 405.1908. Sanctions imposed on the provider under Medicare are automatically imposed under Medicaid. Thus, any conditions imposed by the Secretary on a Medicare provider agreement must be imposed by CDIM on that provider's Medicaid agreement; a denial of Medicare payments for new admissions requires a cor-

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[3]"Conditions" designate broad areas of institutional and patient care functions and services, *e.g.*, "Nursing Services," "Specialized Rehabilitative Services," "Infection Control." *See* 42 C.F.R. §§ 405.1124; 405.1126; 405.1135. "Standards" set forth requirements that must be implemented by SNFs in order to comply with the Conditions. For example, the Specialized Rehabilitative Services Condition sets forth the services that must be offered; the relevant Standards contain requirements regarding staffing, written plans of care, progress reports and documentation. *See* 42 C.F.R. §§ 405.1126; 405.1126(a), (b) and (c). "Factors" are the specific items that must be addressed by the Certification Agency surveyors in the course of their inspections. The HCFA Survey Forms 519 and 525, which list over seven hundred Factors, are eighty-three pages long and therefore have not been reproduced as an appendix to this Brief.

responding denial of Medicaid payments; and termination of a Medicare provider agreement automatically results in termination of the facility's Medicaid provider agreement. 42 U.S.C. § 1395cc(f)(1)(B); 42 U.S.C. § 1396i; 42 C.F.R. § 442.12(a) and (c).

6. CDIM's Medical Review Teams.

The adequacy of care provided to Medicaid-assisted patients is also subject to supplementary oversight by CDIM's Medical Review Teams, which conduct periodic inspections of the adequacy of services available to meet the health needs of these patients. 42 U.S.C. § 1396a(a)(31)(B); 42 C.F.R. § 456.610 *et seq*. Their inspections include observing patients and reviewing their medical records. 42 C.F.R. § 456.608. The Teams must submit reports, including their observations, conclusions, and recommendations, to CDIM, which must forward copies of the reports to the Certification Agency. 42 C.F.R. § 456.611-.612. These supplemental reports are then considered by the Certification Agency (and, through it, by the Secretary) in determining whether to continue or terminate the facility's provider agreement. 42 C.F.R. § 405.1904(b)(2) and (3); 42 C.F.R. § 431.610(g)(1)(i).

The Judgment of the District Court in this case requires CDIM, under certain circumstances, to terminate Medicaid provider agreements solely on the basis of reports of these Medical Review Teams, even though the provider continues to be certified by the Certification Agency as being in compliance with all relevant federal standards and eligible to participate in the Medicaid program. Appendix to Petitioner's Brief at 84A.[4] Thus CAHCF's member SNFs are placed squarely in the midst of potentially conflicting determinations by CDIM and the Certification Agency.

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[4]Citations to the Decisions of the District Court and the Court of Appeals and to the Judgment of the District Court will be by reference to the Appendix submitted with the Commissioner's Petition for a Writ of Certiorari.

Because the Certification Agency simultaneously serves as the designee of the Secretary of Health and Human Services, the Judgment also implicates the role of the federal government and the supremacy of federal quality-of-care standards used in certifying the eligibility of providers for jointly-funded health care programs.

In addition, the practical consequences of termination of a Medicaid provider agreement are severe. Approximately sixty-five percent of the patients residing in skilled nursing facilities in Connecticut receive Medicaid assistance. Termination of a Medicaid provider agreement will result in substantial economic loss and, in most cases, the forced closing of the facility. Termination also requires the transfer of all of the facility's patients receiving Medicaid assistance.

For all of these reasons, the Judgment of the District Court is of vital concern to the member facilities of CAHCF. Therefore, CAHCF submits this Brief in support of the Petition of the Commissioner of Income Maintenance for a Writ of Certiorari to the Second Circuit Court of Appeals.

B. Summary of Argument

The central issue in this case is whether the Medicaid Act and its regulations require that termination of a Medicaid provider agreement for deficiencies in quality of care must be based on non-compliance with federal quality-of-care standards as determined by the Certification Agency. Put another way, the question is whether CDIM can be required or even authorized by a court to terminate provider agreements based solely on the findings by CDIM's Medical Review Team of inadequate care with respect to individual Medicaid-assisted patients.

The statute and regulations make clear that Congress intended to vest authority for monitoring compliance with the comprehensive federal standards governing quality of care in the Certification Agency, which serves as the designee of the Secretary

of Health and Human Services. It is the Certification Agency, applying federal standards, which makes the determination of whether a facility has met the quality-of-care standards required for continued participation in Medicare and Medicaid. The Judgment in this case, requiring CDIM to terminate provider agreements on the basis of Medical Review Team reports alone, violates the established statutory and regulatory scheme. It places state agencies in conflict with each other and the state in conflict with the federal government, all contrary to the purposes and policies underlying the Act.

Moreover, the District Court violates established principles of comity and federalism by imposing upon CDIM the obligation to terminate provider agreements on the basis of Medical Review Team reports even though no such obligation is contained in the Social Security Act. Indeed, the District Court and the Court of Appeals based this obligation upon an interpretation of the Act derived from isolated provisions, phrases and a single disjunctive contained in the regulations. This Court has held that, in cooperative federal-state programs enacted by Congress pursuant to its spending power, Congress may not impose funding obligations upon the states that are not clearly expressed by statute. *Pennhurst State School & Hospital* v. *Halderman,* 451 U.S. 1, 17 (1981). Even though the obligation imposed in this instance is not primarily a funding obligation, the Second Circuit's construction of the Act and relevant regulations is equally disruptive to the states' administration of their Medicaid programs and is equally inconsistent with fundamental principles of comity and federalism. For all of the foregoing reasons, this Court should review the District Court's grant of relief as affirmed by the Court of Appeals.

ARGUMENT

I. The Scope Of Relief As Affirmed By The Court Of Appeals Presents Questions Of Federal Law Of Vital Importance To The States Concerning The Appropriate Roles And Obligations Of State Agencies In The Cooperative Federal-State Program Established Pursuant To Title XIX Of The Social Security Act.

A. The Requirement That The Single State Medicaid Agency Must Terminate Provider Agreements Based On Findings Of Its Medical Review Teams Is Unauthorized By The Act And Disruptive Of The Sound And Efficient Administration By The States Of Their Title XIX Programs.

This case is a class action brought by severely disabled residents of SNFs in Connecticut who receive assistance with payment for the cost of their care from both the federal and state governments under the provisions of Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* The plaintiffs sought injunctive relief requiring the Connecticut Commissioner of Income Maintenance to provide them with specially adapted wheelchairs and related services, including assessment of each individual's need for such a wheelchair and training in its safe and adequate use. App. at 40A.

In the course of its decision, the District Court held that CDIM's Medical Review Teams are required to review the adequacy of the care received by each Medicaid-assisted patient. App. at 64A. The Court then noted 42 C.F.R. § 456.613, which requires CDIM to take "corrective action as needed" based on the report of the Medical Review Team, and held that "corrective action" must be construed to include termination of the Medicaid provider agreement. App. at 66A. It is this holding that conflicts with the overall scheme of the Social Security Act. Congress has clearly articulated that termination of Medicaid provider agreements on grounds of deficient health care can occur only when the Certifi-

cation Agency finds that a facility has failed to comply with federally-mandated quality-of-care standards.

The Judgment not only undermines the authority of the Certification Agency and the Secretary, it also imposes upon the states obligations which Congress did not intend and disrupts the states' sound and efficient administration of their Medicaid programs. In affirming the Judgment, the Court of Appeals improperly relied upon isolated provisions of disparate regulations, including the termination for "good cause" provision of 42 C.F.R. § 442.12(d) and a single disjunctive used in 42 C.F.R. § 431.151. App. at 22A-23A. Such an approach to statutory construction has been rejected by this Court, which has held that "[i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *Philbrook* v. *Glodgett*, 421 U.S. 707, 713 (1975), quoting *United States* v. *Heirs* of *Boisdoré*, 49 U.S. (8 How.) 113, 122 (1850).

By viewing the statutory and regulatory scheme as a whole, the Court of Appeals' error is apparent.

First, the Act creates a structure under which the Certification Agency, not CDIM or its Medical Review Teams, is responsible for the maintenance of quality-of-care standards for Medicaid-assisted patients. 42 U.S.C. § 1396a(a)(9)(A). These quality-of-care standards are set forth in elaborate detail in the comprehensive regulations promulgated by the Secretary known as the Conditions of Participation. 42 C.F.R. § 405.1101-.1137. All Medicare and Medicaid providers must comply with these standards in order to enter into and to continue provider agreements. 42 U.S.C. § 1395x(j)(15); 42 U.S.C. § 1396a(a)(28); 42 C.F.R. § 405.1901 *et seq.*; 42 C.F.R. § 431.610(f)(1).

Second, regulations promulgated by the Secretary under the Act specifically designate the Certification Agency as the sole agency responsible for determining whether providers have met

these requisite Conditions. 42 C.F.R. § 405.1902-.1904; 42 C.F.R. § 431.610(b) and (e). It is the Certification Agency, not CDIM's Medical Review Teams, which conducts the in-depth, detailed and comprehensive on-site inspections required to make this determination. *Id.* As a result of these inspections, the Certification Agency decides whether it will certify to the Secretary that a facility is eligible to participate in Medicare or Medicaid. 42 C.F.R. § 405.1902; 42 C.F.R. § 431.610(b).

Third, the Act and regulations make clear that decisions to impose sanctions on providers for failure to meet quality-of-care standards must be based on the exhaustive review performed by the Certification Agency, not on the more superficial inspections performed by CDIM's Medical Review Teams. Termination of a provider agreement by the Secretary is based on his determination that the facility has not met the Conditions of Participation. 42 U.S.C. §1395cc(b)(2)(A) and (B); 42 U.S.C. § 1395cc(f). Only the Certification Agency is designated by the Secretary to assess compliance with these Conditions. 42 U.S.C. § 1395aa(a). Termination of the Medicare provider agreement by the Secretary effectively causes the termination of an SNF's Medicaid provider agreement as well. *See* 42 U.S.C. § 1396a(a)(28); 42 U.S.C. § 1396i(c); 42 C.F.R. § 442.12(a) and (c); 42 C.F.R. § 442.117. Similarly, if the Secretary decides to impose the alternative sanction of a limitation on admissions, he will order CDIM to deny Medicaid payments for new admissions. 42 U.S.C. § 1395cc(f)(1)(B). All of these consequences flow directly from the assessment of compliance made by the Certification Agency.[5] *See* 42 U.S.C. § 1395aa(a); 42 C.F.R. § 405.1901 *et seq.*

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[5]In the very rare instances of SNFs that have only Medicaid provider agreements and in the case of Intermediate Care Facilities, certification is made directly to CDIM by the Certification Agency. 42 C.F.R. § 442.101(a) and (c). In these instances, CDIM's authority to terminate an agreement is clear; however, the basis for the determination remains the detailed quality-of-care review conducted by the Certification Agency, not reports by the Medical Review Team standing alone.

In view of this tightly structured statutory and regulatory scheme, the reliance of the lower courts on the "good cause" exception for termination by CDIM is misplaced. App. at 23A, 63A. By focusing on 42 C.F.R. § 442.12(d) alone and out of context, the lower courts erroneously concluded that this provision allowed CDIM to terminate provider agreements solely on the basis of reports from the Medical Review Teams. This simplistic analysis usurps the role of the Certification Agency which, with its detailed quality-of-care reviews, is the agency Congress entrusted with assessing the need for termination of agreements with facilities providing substandard care. Significantly, Medicare and Medicaid providers are subject to numerous requirements in addition to the fundamental requirement of compliance with the federal Conditions of Participation, *e.g.*, fraud and abuse and civil rights provisions. *See, e.g.*, 42 U.S.C. § 1320a-3; 42 U.S.C. § 1320a-5; 42 U.S.C. § 1320a-7; 42 U.S.C. § 1395cc(a)(1); 42 C.F.R. § 489.10 *et seq.*; 42 U.S.C. 1396a(a)(32), (35), (38) and (39); 42 U.S.C. § 1396h; 42 C.F.R. § 442.13-.14. Under the similar "good cause" exception governing Medicare providers, the reasons for termination are specified as fraud and abuse, failure to disclose ownership and control interests, bankruptcy or insolvency, and failure to comply with civil rights requirements. 42 C.F.R. § 489.12. There is no basis for construing the Medicaid "good cause" exception contained in §442.12 (d) more broadly.

Fourth, in contrast to the well-established role of the Certification Agency, the role of CDIM's Medical Review Teams in assessing quality of care is subordinate and sharply limited.

By statute, Medical Review Teams (called "professional review teams" in the Act) are charged with inspecting "the adequacy of the services available to meet [the individual patient's] current health needs and promote his maximum physical well-being."[6] 42 U.S.C. § 1396a(a)(31)(B)(i). The regulations gov-

[6]The Teams also review the necessity for institutionalization and the fea-

(Footnote continued on following page)

erning the Medical Review Teams do not set forth specific standards but instead provide that the Teams must determine whether services are adequate to "[m]eet the health needs of each recipient . . . and . . . [p]romote his maximum physical, mental, and psychosocial functioning." 42 C.F.R. § 456.609(a)(1) and (2). In making this determination, the Teams should observe:

"(1) Cleanliness;
(2) Absence of bedsores;
(3) Absence of signs of malnutrition or dehydration; and
(4) Apparent maintenance of maximum physical, mental and psychosocial function."

42 C.F.R. § 456.610(e). It is apparent that the type of inspection conducted by the Teams is substantially less detailed than that performed by the Certification Agency, which must address and determine compliance with the seven hundred separate Factors included in the eighteen comprehensive Conditions of Participation.

The Medical Review Teams must make reports, including recommendations, to CDIM. 42 C.F.R. § 456.611. CDIM in turn is required to forward a copy of each report to the Certification Agency. 42 C.F.R. § 456.612(c). The Certification Agency is required to review and consider these supplemental reports as part of its assessment of whether a facility is qualified to participate in Medicare and Medicaid. 42 C.F.R. § 405.1904(b)(2) and (3); 42 C.F.R. § 431.610(g)(1)(i). These regulations

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(Footnote continued from previous page)

sibility of noninstitutional care. 42 U.S.C. § 1396a(a)(31)(B)(ii) and (iii). While these Teams assess patient care, the evaluation is principally to determine whether the care actually given is commensurate with the patient's physical condition and level of classification, *i.e.*, skilled nursing care or intermediate care. 42 C.F.R. § 456.609-.611. The determination of appropriate levels of care has reimbursement implications for the provider for which CDIM, as the single state agency, has primary responsibility. 42 U.S.C. § 1396a(a)(5).

make clear that the Teams' role is subordinate to that of the Certification Agency and that any decision to terminate a provider agreement based on the Teams' report must be made through that Agency.

Although CDIM is required by regulation to take "corrective action as needed" based on the Teams' reports, 42 C.F.R. § 456.613, that phrase is not defined and cannot properly be construed in isolation apart from the entire statutory and regulatory framework. The Act and regulations clearly require that decisions regarding provider terminations based on quality of care originate with the comprehensive assessment conducted by the Certification Agency. Any construction of the phrase "corrective action as needed" that includes provider terminations based on the Teams' findings alone is erroneous. Reports of Medical Review Teams may furnish part of the basis for the Certification Agency's assessment, but CDIM cannot act on these reports independently, in derogation of the authority vested by Congress in the Secretary and the Certification Agency.

The specific language of the statute and regulations also is instructive with regard to the appropriate role of the Medical Review Teams. The function of the Teams is to determine whether available services are "adequate to . . . [m]eet the health needs of each recipient . . . and . . .[p]romote his maximum physical, mental, and psychosocial functioning." 42 C.F.R. § 456.609(a)(1) and (2). *See also* 42 U.S.C. § 1396a(a)(31)(B)(i). This Court repeatedly has held, especially in the context of cooperative federal-state programs, that such language cannot be read as prescribing substantive standards but instead indicates goals and objectives. For example, in *Pennhurst State School & Hospital* v. *Halderman,* 451 U.S. 1 (1981), this Court refused to construe the language of 42 U.S.C. § 6010 describing "appropriate treatment, services and habilitation . . . designed to maximize the developmental potential of the person" as creating rights to specific kinds of treatment. 451 U.S. at 27. Similarly, in *Alexander* v. *Choate,* 469 U.S. 287 (1985), the Court held that the phrase

"adequate health care" could not be construed to require that Medicaid patients receive specific benefits precisely tailored to their individual needs. 469 U.S. at 302-03.

In its Judgment, the District Court appears to have assumed that the statute and regulations governing Medical Review Teams set forth standards which would furnish a separate basis for termination of provider agreements. However, in accordance with the principles set forth in *Pennhurst* and *Alexander*, the language of the statute and regulations cannot properly be construed to reach such a result. At least to the extent that the Judgment implies the existence of such standards, it is inconsistent with the holdings of this Court cited above.

The statute and regulations, construed as a whole and in accordance with prior holdings of this Court, make clear that reports of Medical Review Teams in themselves cannot furnish the basis for termination of provider agreements. Assessment of compliance with federal quality-of-care standards is committed to the Certification Agency and any termination of a provider agreement based on failure to comply with these standards must flow from the Certification Agency's determinations. This interpretation permits the complementary co-existence of the Medical Review Team and the Certification Agency that is essential to the sound and efficient administration by the states of their Medicaid plans.

If the affirmance by the Court of Appeals of the scope of relief granted by the Judgment is allowed to stand, the conflicting roles of CDIM and the Certification Agency may result in contradictory determinations disruptive of federal-state relations and the harmonious functioning of the states' programs. The interpretation of the statute and regulations by the District Court and the Court of Appeals is inconsistent with the integrated statutory scheme and with the Secretary's own regulations. These important inconsistencies in the construction of a wide-reaching federal law should be reviewed by this Court.

B. The Scope Of Relief Granted In This Case Conflicts With Prior Decisions Of This Court Holding That Obligations Imposed On The States By Congress Through Legislation Enacted Pursuant To Its Spending Power Must Be Affirmatively And Unambiguously Expressed.

Title XIX appropriates federal funds "[f]or the purpose of enabling each State . . . to furnish (1) medical assistance on behalf of [certain classes of persons], whose income and resources are insufficient to meet the cost of necessary medical services, and (2) rehabilitation and other services to help [these persons] attain or retain capability for independence or self-care." 42 U.S.C. § 1396. The Medicaid program has been described by this Court as a program of "cooperative federalism." *King* v. *Smith*, 392 U.S. 309, 316 (1968). In such cooperative programs, the federal government can impose on the states only those obligations which Congress clearly intended to impose. Attempts to impose broader obligations are barred by the principles of comity and federalism.

In *Pennhurst State School & Hospital* v. *Halderman*, 451 U.S. 1 (1981), this Court addressed certain provisions of the Developmentally Disabled Assistance and Bill of Rights Act, a federal statute "designed as a cooperative program of shared responsibilit[ies]" similar in structure and intent to the Medicaid statute. 451 U.S. at 22. In construing the obligations of the states to provide particular kinds of treatment and services under the Act, the Court found that

> legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a

> condition on the grant of federal money, it must do so unambiguously.

451 U.S. at 17 (citations omitted). *See also Board of Education v. Rowley*, 458 U.S. 176, 204 n.26 (1982).

The relief granted by the District Court in this case construes Title XIX of the Social Security Act as requiring CDIM to terminate provider agreements based on findings made by its Medical Review Teams alone. This construction is not based on any unambiguous requirement of the Act, but instead is based on isolated phrases and a single disjunctive contained in regulations. For example, the Court of Appeals cited the disjunctive contained in 42 C.F.R. § 431.151 as evidence that a provider agreement may be terminated even though the facility continues to be certified by the Certification Agency as complying with all conditions and standards governing quality of care. This takes § 431.151, which is a *procedural* regulation granting no substantive authority, completely out of context.

In no instance did the Court of Appeals cite any unambiguously expressed provision of the statute or, indeed, any provision of the statute, as the basis for its affirmance of the obligations imposed by the District Court. Instead, it concluded only that the relief ordered by that Court was "not precluded" by the Act. App. at 24A.

As set forth in Section I. *supra*, the District Court's imposition on CDIM of an obligation to terminate provider agreements solely on the basis of Medical Review Team reports is unauthorized by the statute. The obligation in this case is not primarily an obligation to fund particular services, such as the plaintiffs in *Pennhurst* sought to impose. Nevertheless, the District Court's Judgment is equally disruptive to the sound administration by the states of their Medicaid programs and equally inconsistent with fundamental principles of comity and federalism. The Judgment in this case should be reviewed by this Court because it conflicts

with the holding of *Pennhurst* and does violence to the federal statutory scheme governing quality-of-care reviews and provider eligibility to participate in the Medicaid program.

Conclusion

Because the Judgment of the District Court violates the comprehensive statutory scheme governing compliance with federal health care standards set forth in Titles XVIII and XIX of the Social Security Act, and conflicts with prior holdings of this Court, the Connecticut Association of Health Care Facilities, Inc. joins the Connecticut Commissioner of Income Maintenance in respectfully requesting review of the Judgment by this Court.

Respectfully submitted,

STEPHEN E. RONAI
H. KENNEDY HUDNER
(Counsel of Record)
MARTHA EVERETT MENG

MURTHA, CULLINA, RICHTER AND PINNEY
CityPlace — P.O. Box 3197
Hartford, Connecticut 06103-0197
(203) 240-6000

Counsel for *Amicus Curiae*

No. 86-747

In The Supreme Court Of The United States

OCTOBER TERM, 1986

STEPHEN B. HEINTZ, Commissioner of the Connecticut Department of Income Maintenance,
Petitioner,

v.

DALE HILLBURN, by his parents and next friends Ralph and Eleanor Hillburn, et al.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF THE STATES OF INDIANA AND PENNSYLVANIA AS AMICI CURIAE IN SUPPORT OF THE GRANT OF CERTIORARI

LINLEY E. PEARSON
Attorney General
WILLIAM E. DAILY
Assistant Attorney General
Counsel of Record
219 State House
Indianapolis, Indiana 46204
(317) 232-6217

LEROY S. ZIMMERMAN
Attorney General
Strawberry Square
Harrisburg, PA 17120
(717) 783-1471

Printed by
Brescia's Printing Services
66 Connecticut Boulevard
East Hartford, CT 06108
525-6029

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INTEREST OF THE AMICI

Amici are the states of Indiana and Pennsylvania acting by and through their Attorneys General. *Amici,* by and through state public welfare agencies, voluntarily participate in the Medicaid program and thereby make available publicly financed health care to their citizens who would not otherwise be able to afford the cost of medical care, notably including nursing facility care. As participants in the Medicaid program, *amici* are required to adhere to the conditions of participation in the program, including the condition of participation that requires the state Medicaid "single state agency" to afford program recipients the right to receive covered services from the qualified provider of their choice. 42 U.S.C. § 1396a(a)(23).

In addition, the *amici,* by and through separate and distinct state health inspection agencies, are responsible for establishing and maintaining health standards for facilities that participate in the program and for determining whether or not facilities are qualified to participate in the program. 42 U.S.C. § 1396a(a)(33)(B). *Amici* urge that certiorari be granted in order for this court to clarify important questions concerning the quality of care enforcement responsibilities of the states under the Medicaid program.

REASONS FOR GRANTING THE WRIT

The *amici* states of Indiana and Pennsylvania urge this Court to grant a writ of certiorari to the United States Court of Appeals for the Second Circuit in order to provide plenary review of the decision below which raises issues of considerable importance to the states.

The quality of care provided by nursing facilities that participate in the Medicaid program and receive public financing for the cost of services provided to program beneficiaries is a matter of substantial public concern. Congress addressed the quality of care concerns through a program of "cooperative federalism" wherein state health inspection agencies and the Secretary of the United States Department of Health and Human Services have shared responsibilities for determining whether or not facilities are qualified to participate in the program. Specifically, the Act requires state health inspection agencies to establish and maintain standards of care, 42 U.S.C. § 1396a(a)(9), and to determine through the "survey and certification" process whether or not facilities are qualified to participate in the program. 42 U.S.C. § 1396a(a)(33)(B). The determinination of whether a facility is qualified requires a determination by the state health inspection agency of whether the facility as a whole substantially complies with the conditions of participation and whether the facility's plan to correct any deficiencies is acceptable. 42 C.F.R. 442.105(a) and (b). An opportunity to contest the certification determination of the state survey agency must be provided through state administrative proceedings. 42 C.F.R. § 431.151.

Whenever any facility also participates in the Title XVIII Medicare program, however, the Secretary of Health and Human Services is responsible for determining whether or not the facility is qualified to participate in the Medicaid program —which determination is binding upon the states. 42 U.S.C. § 1396i. Even if the facility does not participate in Medicare, however, the Secretary is authorized to "look behind" the determination of the state health inspection agency as to

whether or not a facility is qualified to participate in the program. 42 U.S.C. § 1396a(a)(33)(B).

Once a facility has been determined to be qualified to participate in the program, recipients of medical assistance are entitled to receive payment for the cost of services provided. 42 U.S.C. § 1396a(a)(23).

In addition to the survey and certification responsibilities of the state health inspection agency, the Act requires that inspections be conducted of the adequacy of health care provided to each Title XIX-assisted individual by participating skilled nursing facilities. 42 U.S.C. § 1396a(a)(31). Except for the requirement that inspections be conducted, and reports of findings be forwarded to the state health inspection agency, there is no indication in the Act of the regulatory authority, or responsibility, of the single state agency to take action based upon findings of deficiencies with respect to individual patients. The Court below, however, upheld a requirement that the Connecticut Department of Income Maintenance terminate the provider agreement of certified facilities, based upon individual deficiencies, which order requires the Connecticut single state agency to contravene the statutory rights of every Title XIX-assisted patient in the facility to receive assistance for the cost of services provided by the qualified (certified) provider of their choice.

The holding of the court below raises issues of considerable importance to the states that warrant review by this Court, notably including the appropriateness of an order that requires a state to violate the statutory rights of its citizens to receive covered services from qualified providers. The appropriateness of any order that has the effect of requiring the forced relocation of elderly and infirm citizens from a *qualified* facility because of individual deficiencies in the care provided to *other* patients raises issues of obvious concern and importance.

In addition, however, *amici* are most concerned about the confusion in the roles of the state health inspection agency

and the single state agency evidenced by the Court below. It is basic that state agencies may only act within the scope of their authority and responsibility. Furthermore, it is a fundamental principle of § 1983 litigation that relief against a public official may only be based upon personal responsibility and accountability. *Rizzo v. Goode,* 423 U.S. 362 (1976). The decision of the court below, however, misconceives the scope of responsibilities of the single state agency for quality of care enforcement and requires the head of the Connecticut single state agency to take action that is beyond the scope of his statutory responsibility. As *amici* demonstrated, *supra,* the clear focus of quality of care enforcement is on the state health inspection agency and not on the single state agency for purposes of administration. Certiorari should issue to clarify the respective responsibilities of the single state agency and the state health inspection agency for purpose of quality of care enforcement.

Furthermore, the Act contemplates that quality of care will be enforced through state administrative mechanisms undertaken by the state health inspection agency. The Court below allows private litigants and the federal courts to supplant the administrative mechanisms provided for in the Act. In this action, private § 1983 litigation resulted in the entry of remedial relief against the single state agency, notwithstanding the absence from this litigation of the entities who are most directly responsible for ensuring quality care — the nursing facilities themselves and the state health inspection agency. Certiorari should therefore issue to clarify that the administrative mechanisms provided for in the Act may not be bypassed by § 1983 litigation.

Finally, the importance of the case transcends the need of the states for clarification of the quality of care enforcement responsibilities under the Medicaid Act. This Court has repeatedly held that public officials may only be required to adhere to clearly stated, mandatory conditions of participation in programs enacted pursuant to Congress' spending authority. *Pennhurst State School v. Halderman,* 451 U.S.1

(1981); *Middlesex County Sewerage Authority v. National Sea Clammers,* 453 U.S.1 (1981). The Court below, however, upheld the judgment of the District Court based only upon its conclusion that the relief ordered by the District Court, including the requirement of termination of provider agreements, was "not precluded" by the Act. Certiorari should issue in order for this Court to review whether a court may appropriately enjoin public officials to take action which is not authorized, or required, by the Act based solely upon notions of the appropriate exercise of judicial discretion. The Court below in effect created a remedy for individual deficiencies (termination of provider agreements) and enjoined the Connecticut single state agency to take such action when other remedial steps (beyond the control of the single state agency) fail to remedy the situation in the absence of any legislative direction authorizing such relief. Furthermore, the remedy created by the Courts below squarely conflicts with explicit statutory provisions linking a facility's participation to its certification. 42 U.S.C. § 1396a(a)(33)(B); 42 U.S.C. § 1396i.

Legislative clarification of the enforcement role of patient review team findings concerning individual patients may be indicated. However, the *amici* states are confident that Congress would provide a remedy that is tailored to the individual violation. The Court below, however, improperly usurped legislative functions by creating a remedy for individual deficiencies. Furthermore, the remedy created by the Courts below is clearly inconsistent with the survey and certification methodology provided for in the Act to make the determination of whether or not a facility is qualified to participate in the program.

CONCLUSION

For the foregoing reasons, the *amici* states urge that this court grant the petition for a writ of certiorari.

Respectfully Submitted

LINLEY E. PEARSON
Attorney General
of Indiana

WILLIAM E. DAILY
Assistant Attorney General
Counsel of Record

LEROY S. ZIMMERMAN
Attorney General
of Pennsylvania